

**PART 2**  
**HEALTH PLANNING AND RESOURCES**  
**DEVELOPMENT AMENDMENTS OF 1978**

---

**HEARINGS**  
**BEFORE THE**  
**SUBCOMMITTEE ON**  
**HEALTH AND THE ENVIRONMENT**  
**OF THE**  
**COMMITTEE ON**  
**INTERSTATE AND FOREIGN COMMERCE**  
**HOUSE OF REPRESENTATIVES**  
**NINETY-FIFTH CONGRESS**  
**SECOND SESSION**  
**ON**  
**H.R. 10460**

A BILL TO AMEND TITLES XV AND XVI OF THE PUBLIC  
HEALTH SERVICE ACT TO REVISE AND EXTEND THE AU-  
THORITIES AND REQUIREMENTS UNDER THOSE TITLES FOR  
HEALTH PLANNING AND HEALTH RESOURCES DEVELOPMENT

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JANUARY 30, 31, FEBRUARY 1, AND 2, 1978

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**Serial No. 95-94**



Printed for the use of the  
Committee on Interstate and Foreign Commerce

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WASHINGTON : 1978

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## ORGANIZATIONS REPRESENTED AT HEARING

- American Clinical Laboratory Association:
  - Halper, Robert, general counsel.
  - Johnson, Gifford, president.
- American Dental Association:
  - Bishop, Eric, assistant executive director for dental health.
  - Kerr, I. Lawrence, D.D.S., member, board of trustees.
- American Federation of Labor and Congress of Industrial Organizations:
  - McGlotten, Robert, legislative representative, department of legislation.
  - Siedman, Bert, director, department of social security.
  - Shoemaker, Richard, assistant director, department of social security.
- American Health Planning Association:
  - Hanson, Jacqueline B., treasurer.
  - Matek, Stanley J.
- American Hospital Association:
  - Gehrig, Leo J., senior vice president.
  - McMahon, John Alexander, president.
- American Medical Association:
  - Hill, Dan, assistant director, legislative department.
  - Jirka, Frank J., M.D., vice chairman, board of trustees.
  - Johnson, Archie T., M.D., ad hoc Committee on Planning.
  - Peterson, Harry N., director, legislative department.
- American Osteopathic Association:
  - Adler, Philip, D.O., president.
  - Perin, John P., director, Washington office.
- American Osteopathic Hospital Association:
  - Cooper, Gerson I., chairman, Government relations committee.
  - Doody, Michael, F., president.
- Association of American Medical Colleges:
  - Cooper, John A. D., M.D., president.
  - Everhart, David, on behalf of.
- Association of State and Territorial Health Officials, Arthur Y. Webb, on behalf of.
- Birmingham Regional Health Systems Agency, Inc., Albert H. Rohling, executive director.
- Blue Cross Association, Neil Hollander, vice president.
- Central Georgia Health Systems Agency, Don Trantow, executive director.
- Central Northeast Colorado Health Systems Agency, Anne Fenerty on behalf of.
- Champaign County (Illinois) Health Care Consumers, Barry Checkoway, on behalf of.
- Consumer Coalition for Health, Herbert Semmel, president.



## ORGANIZATIONS REPRESENTED AT HEARING—Continued

- East Kentucky Health Systems Agency, Tony Goatz, executive director.
- Federation of American Hospitals:  
 Bromberg, Michael D., executive director.  
 Samsel, Robert J., president.
- Georgia Legal Services Programs:  
 Biskind, Eve.  
 Greene, Melisa, paralegal.  
 Pressell, Wayne.
- General Accounting Office:  
 Fernstermaker, Carl, Assistant Director, Human Resources Division.  
 Gerkins, William, Supervisor, Auditor, Human Resources Division.  
 Martin, James D., Deputy Director, Human Resources Division.
- Greater Detroit Area Hospital Council, Symond R. V. Gottlieb, executive director.
- Group Health Association, Inc., Louis J. Segadelli, executive director.
- Health, Education, and Welfare Department:  
 Champion, Hon. Hale, Under Secretary.  
 Davis, Karen, Deputy Assistant Secretary for Planning and Evaluation (Health).  
 Foley, Henry A., M.D., Administrator of Health Resources Administration.  
 Hanft, Ruth S., Deputy Assistant Secretary for Health Research and Statistics.
- Health Industry Manufacturers Association, Harold O. Buzzell, president.
- Health Insurance Association of America, Henry A. DiPrete, on behalf of.
- Health Planning Council of the Eastern Shore, Inc.:  
 Dierks, Fred, executive director.  
 Parr, Col. Bertram (USA Ret.), vice president.
- Homemakers Upjohn, Budd J. Norris, president.
- Hospital Financing Study Group:  
 Greene, Thomas III.  
 Quinn, Thomas H., general counsel.
- Iowa State Health Planning Agency, Cooper L. Parker, director.
- Kaiser Foundation Health Plan, Inc.:  
 Lane, James A., vice president and counsel.  
 Newman, H. Frank, M.D., vice president.
- Medical Society of Virginia, William J. Hagood, Jr., M.D., president.
- Michigan Cost Containment Coalition, Jack K. Shelton, on behalf of.
- Michigan Hospital Association, Leo Greenawalt, vice president for governmental affairs.
- Mid-America Regional Council, Peter Levy, executive director.
- National Association of Counties, Mike K. Gemmell, associate director for health and education.
- National Association of Regional Councils, Roger L. Smith, on behalf of.
- National Association of Single State Agencies, Richard Neibaur, chairman.
- National Conference of State Legislatures, Hon. Elaine Gordon (Florida State representative).
- National Congress of American Indians:  
 Carmady, Theresa, on behalf of.  
 Press, Daniel, counsel.
- National Council of Senior Citizens, Einar Mohn, on behalf of.
- National Electrical Manufacturers Association (NEMA), Radiation Imaging Products Division, Robert G. McCune, on behalf of.
- National Indian Health Board, Inc., Theresa Carmady, on behalf of.
- Northern California Association of Health Systems Agencies, Art Gilman, chairman.
- Public Citizens Health Research Group:  
 Bogue, Ted, attorney.  
 Wolfe, Sidney, M.D., director.
- Regional Centers for Health Planning, James R. Kimmey, M.D., on behalf of.
- Southeastern Association of Health Systems Agency Executives, Albert H. Rohling, president.
- Southern Regional Council, Steve Suitts, executive director.
- Texas Hospital Association, O. Ray Hurst, president.
- Texas Statewide Health Coordinating Council, Louis E. Gibson, M.D., chairman.
- Western Colorado Health Systems Agency, Inc.:  
 Hoskins, Dorothy, president.  
 Meyer, Dave, executive director.



## HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978

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THURSDAY, FEBRUARY 2, 1978

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,  
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,  
*Washington, D.C.*

The subcommittee met pursuant to notice at 10:45 a.m., in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please.

We are continuing hearings on the Health Planning and Resource Development Amendments of 1978.

We are pleased to have as our first witness the Honorable Arlan Stangeland from Minnesota who is very much interested in this matter.

We welcome you and your statement will be made a part of the record, and you may proceed as you desire.

### STATEMENT OF HON. ARLAN STANGELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. STANGELAND. Thank you, Mr. Chairman. I appreciate the opportunity to speak before you this morning on the revised extension and amendment of the Health Planning and Resources Development Act. We all know that Government moves slowly, but it is 1978 and we are just now beginning to implement fully the provisions of this legislation which was initially enacted in 1974. Therefore, let me preface my remarks with the fact that we obviously need to extend the law and we definitely need to amend it.

My primary concern is the small rural hospital. I represent the seventh district of Minnesota which has approximately 300 small towns and covers over 60,000 square miles. In this sparsely populated area, the continued existence of small hospitals is vital.

As we all know, the Department of Health, Education and Welfare last September issued proposed health planning guidelines which imposed unrealistic requirements on rural hospitals. I do appreciate the Department's response to the outpouring of comments on these proposed guidelines. As a result of more than 55,000 communications received by the Department—54,000 of which seemed to have arrived in my office—it has recently revised the guidelines to allow a good deal of discretion for local health systems agencies in determining the accessibility of hospital care [see p. 882].

The point I wish to make is that a lot of time, worry and bureaucratic procedure could have been avoided if the law itself explicitly states that such local discretion would be granted.

As you know, we will soon be considering the Postal Service subsidy legislation. I think that we must realize what a large part the Government itself plays in creating the need for a subsidy in placing an often unnecessary burden on this public service. Fifty-five thousand pieces of mail could possibly have been eliminated by doing some homework prior to issuing regulations and guidelines. The Federal Government must begin somewhere to eliminate red tape and return control of their lives to the citizens themselves.

It is my understanding that the recent guidelines are the first in a series of such proposals. We now have the opportunity to experiment in good Government by allowing local communities to decide how their needs may best be met. Instead of solving each situation with an ad hoc solution, we should determine beforehand what the policy will be—and I urge that it be local input and control.

Of course, we all recognize the need to reduce health care costs. I would like to point out that Federal control does not necessarily insure reduced costs nor better service. Two small hospitals in my district, which seem to be representative, have records of which I am proud. In Aitkin County, whose population is approximately 12,000, the average cost for 1977 for a day's hospitalization was \$121 and the average length of stay was 5.9 days. Another community hospital in Warren, which serves a county of 14,000 managed to provide hospital care last year for \$109 per patient day and kept its patients a little over 5 days per average stay. This compares with a national average of approximately \$170 per day and an average stay of more than 8 days.

During your deliberations on the proposed changes to this legislation, I most earnestly request that you approve language which formalizes the concept of local control by explicitly stating that local health systems agencies and the communities which they represent will be given all possible discretion in the administration of health care planning. By imposing guidelines from above, even though they may later be revised to allow more flexibility, we automatically implant in the minds of the local Health Systems Agencies the idea that they must meet these requirements. What we actually need is initial input from the affected communities who are free to express their ideas without any fear of coercion on the part of the Federal Government. We should start from the bottom up. Rather than proposing rigid and unrealistic guidelines, a little effort spent in consulting with local communities regarding their particular needs and requirements could eliminate a mass of communications, confusion and misunderstandings.

In concluding, I would like to mention that here in Washington, with our immediate access to the finest health care available, we possibly do not realize the effect which proposals, such as those initially passed, can have on a small, rather isolated community. In Minnesota we have long, hard winters and we work hard in often physically demanding and hazardous occupations. The comfort de-



rived from the knowledge that health care is available and that medical emergencies can be dealt with does not have a price tag. I was particularly concerned over the many letters which I received from the elderly population in my District. In our area older people who retire from the farm tend to concentrate in these small communities which the hospitals serve. A real, everyday concern to them is the availability of health care.

I cannot emphasize too greatly the need to assure that these small hospitals are preserved. From their record of cost efficiency, I do not think we are granting any favors. Indeed, we may wish to consult with them to benefit from their experience.

That is the end of my testimony, Mr. Chairman.

If there are any questions, I would be happy to attempt to respond.

[Testimony resumes on p. 906.]

[The following letters were received for the record:]

ARLAN STANGELAND  
7TH DISTRICT, MINNESOTA

COMMITTEES:  
GOVERNMENT OPERATIONS  
PUBLIC WORKS AND  
TRANSPORTATION

**Congress of the United States**  
**House of Representatives**  
Washington, D.C. 20515

OFFICES:  
1518 LONGWORTH HOUSE OFFICE BUILDING  
WASHINGTON, D.C. 20515  
(202) 225-2145

M-F BUILDING  
403 CENTER AVENUE  
MOORHEAD, MINNESOTA 56560  
(218) 233-8631

February 9, 1978

The Honorable Paul G. Rogers  
Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
U. S. House of Representatives  
Washington, D. C. 20515

Dear Mr. Chairman:

I would very much appreciate your including the enclosed material as a part of the official record on the proposed extension and amendment of the Health Planning and Resources Development Act.

Thank you for your attention in this matter.

With best regards, I am

Sincerely,

*Arlan Stangeland*  
Arlan Stangeland  
Member of Congress

Enc1

FEB 6 1978

## Bemidji Community Hospital

805 DEWEY AVENUE BEMIDJI, MINNESOTA 56601

218/751-5430

February 1, 1978



Administrator: LEON C. SWANSON

The Honorable Arlan Stangeland  
House of Representatives  
1518 Longworth House Office Building  
Washington, D.C. 20515

RE: Amendments to and Extension of P.L. 93-641

Dear Mr. Stangeland:

As a member of the Seventh District's Health Care Advisory Committee, I have been requested by Mr. Mark Wedel to comment on the upcoming hearings of the House Subcommittee on Health and the Environment, which will consider proposed amendments to and the extension of P.L. 93-641. Due to the relatively short time we have in which to respond to your request for information, my comments will be somewhat brief and general.

The Bemidji Community Hospital, which is a member of the Minnesota Hospital Association (MHA), concurs with MHA in its strong support of the population-based comprehensive health planning process established in P.L. 93-641. Since the Health Systems Agencies (HSAs) are in the best position to evaluate the needs and demands of their constituents, we endorse MHA's position to have the planning process begin at the local HSA level. We request that the proposed amendments give the authority for planning to the local HSAs and permit the continued representation of our hospitals and nursing homes on the HSA board.

Section 1513b (2) currently directs the local HSAs to develop plans that are "responsive to the needs and resources of the area" within a framework of state and national priorities. We hope that Congress will continue with this language, which allows the local HSA to develop its own plan. We further hope that Congress will give directives to the Department of Health Education and Welfare which will permit the HSAs to develop their plans in the best manner they deem necessary. With the tremendous number of negative responses to the National Guidelines proposed in September 1977, it is clear that the health care industry has gone on record to support health planning at the local level and not at the federal agency level.

If the Certificate of Need law requirements under P.L. 93-641 are to achieve the expected goal of reducing expensive duplication, the law must be expanded to include all health care providers and the now-exempt federal

An equal opportunity employer

facilities, i.e., Veterans Hospitals and P.H.S. Hospitals. Currently federal facilities must be represented on HSA boards, but are not included under the law.

The task before our HSAs is formidable indeed. If they are to be at all successful in their endeavors, Congress must give them the authority or means by which to obtain adequate funds. The HSAs should be permitted, therefore, to seek funds from non-governmental sources.

We again welcome this opportunity to express our opinions to you for your consideration.

Best regards,

A handwritten signature in dark ink, appearing to read "James W. Maki". The signature is fluid and cursive, with the first name "James" being more prominent and the last name "Maki" following in a similar style.

James W. Maki  
Assistant Administrator

cc: J. Mark Wedel, Chairman  
Health Care Advisory Committee  
Minnesota Hospital Association



FEB 6 1978

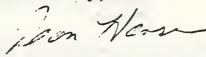
Red Lake Falls, MN 56750  
February 1, 1978

The Honorable Arlan Stangeland  
House of Representatives  
Washington, D.C. 20515

Dear Mr. Stangeland:

I am writing in regard to Public Law 99-641 which is currently in public hearing. I serve on the board of directors of an area health systems agency. In this capacity I have seen the need for rural HSAs to function as a means of controlling facilities and placement of health care. This letter is a request for increased minimum funding. It is interesting to note that a law has been enacted for HSAs, yet it is very difficult to receive the proper level of funding. With the large rural area that our HSA serves, the costs are significantly higher than in some of the metro areas because of distance in accessibility of areas, etc. Therefore, I would very much appreciate an increase in minimum funding if we are to have this kind of health systems agency concept.

Sincerely,

  
Jean Hanson

mca

## ST. JOSEPH'S HOSPITAL

FEB 7 1978

Park Rapids, Minnesota 56470

Telephone 732-3311

January 30, 1978

Re: Funding of HSA's under PL 93-641

Representative Alan Stangland  
 Box 726  
 Detroit Lakes, M 56560

Dear Representative Stangland:

I write to you both as a Board member of the Agassiz Health Systems Agency and as a hospital administrator in the area concerned.

I ask you to consider input into the hearings now being held on PL 93-641 for increased minimum funding for HSA's. In addition I ask that consideration be given to funding the Area Health Services Development Fund - congressionally authorized but never funded.

My reasons are:

1. While all HSA's must perform the same functions, rural HSA's usually do not have the same funding capabilities as metro HSA's.
  - a. Last year Agassiz found it necessary to use \$10,000 of local funds; this year about \$20,000 over minimum funding and next year there will be little or none - which means a reduction in staff, already at minimum.
  - b. Although I believe the law intended matching funds based on population but we have not been able to apply for this because of our population base (314,000 in 27,000 square miles).

Additionally it would seem appropriate to consider additional funding for bi or multiple state agencies because additional costs are incurred.

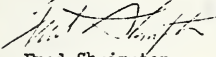
1. We have a large area to cover - both for staff, Board and Committees.
2. We must meet with SHPDA's in two states in order to arrive at common development and implementation plans - no small task with different viewpoints with which to contend.

In order for Agassiz and other rural HSA's to remain viable it is imperative that:


1. Minimum HSA funding be increased to at least \$225,000.
2. Some change be made to allowing matching funds based on a different population formula.
3. Additional funding be made available for those HSA's which cross state or regional lines.

Your serious consideration of these matters will be most appreciated.

Very sincerely yours,

  
Fred Shrimpton

cc: Donald E. De Mers  
Executive Director  
Agassiz Health Systems Agency

*John -*  
*Long I meant you at the breakfast in New Haven*  
*a few weeks ago - I was told to be there*  
*but had a last minute conflict*  




## Agassiz Health Systems Agency

123 DE MEIS AVENUE  
EAST GRAND FORKS, MN 56721

DONALD E. DE MERS  
Executive Director

### OFFICERS:

Paul Wouret, Chairman  
Ernest Lugiv, Vice-Chairman  
Clarence Lee, Secretary  
Jesse Burke, Treasurer

December 28, 1977

### ADVISORS:

Margaret Allmaras  
Mrs. Carroll Anderson  
Arthur Bliden, Jr.  
Jerry Blanchard, D.C.  
James Brown, M.D.  
Eileen Chapman  
J. J. Connor  
William Dincoteau  
Homer Levesley  
Alvin Dremseth  
Paul J. Erickson  
Klaus Eitzen  
Walter Fenske  
Lori Goranson  
Knutrud Hultstrom  
Lee Swallum  
Joan Macdon  
Mary Mary Jorgensen  
John Mills  
Stanley Weistad  
Howard Nove

Honorable Arlan Stangeland  
4th Floor, FM Center  
403 Center Avenue  
Moorhead, MN 56560

Dear Congressman Stangeland:

I first want to wish you a warm holiday season and tell you how much I enjoyed visiting with you at the Chamber of Commerce offices in East Grand Forks. (I'm the Councilman who told you the train slowed down so people could wave at you.)

I did mention that I would be getting back to you because of the expected changes pending in the Health Planning and Resources Development Act - P.L. 93-641.

There are some changes our agency would like to see in the law, and I will get back to you detailing out changes necessary to assist health planning in our rural area of Northeast North Dakota and Northwest Minnesota.

The most critical issue we face at this time is the need for a higher minimum funding level for our rural Health Systems Agencies.

We are expected, in fact we are required, to perform the same functions as any large metropolitan based health systems agency.

I do not particularly desire large federal handouts to accomplish those things we can do at a local level, but P.L. 93-641 is a good federal strategy to give local planning areas an opportunity to plan and determine the services we want and need.

As the attached letter documents, without a higher minimum funding level our agency will go belly-up.

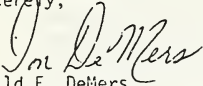
If there is anything (information, visits, etc.,) I can do to assist you in this endeavor please call on me. My Board of Directors (of

Robert Jacobson  
Marlys Jackson  
Richard Jackson  
John Jensen, M.D.  
W. J. Johnson  
Bertrich Kuch  
Albert Kono  
Robert Kono  
Landra Kozola  
John Lalonde, M.D.  
David Landin  
Arnold Lange  
Dorian Lalucque  
Rev. John Lee  
Donald Leonard  
Gerrys Lindenberg  
Gavin Lorde  
Jesse Mallins  
R. L. Williams, M.D.  
Lalene Mogen  
F. W. Paulberg  
Kurtie Pelly  
Patricia Rotten  
John Rodriguez  
Irene St. George  
L. and Sammie, D.M.D.  
John Sipe  
Karen Soltau  
Gordon Summers  
Luis Stanislawski  
Lori Swanson  
Karen Swamney  
Mark Turk  
John Vennos, Ph.D.  
Mary Wied

64 - representing consumers, providers, and elected officials of your district) has encouraged this contact, and I am writing this letter with their support.

Again thanks for a pleasant evening, and I look forward to your response and help.

Sincerely,



Donald E. DeMers  
Executive Director

1b

Enclosure



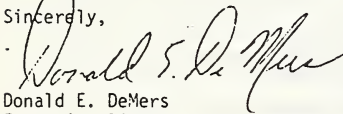
Our agency has been a dues paying member of AACHP now AHPA since its inception. I hope to be able to continue to support AHPA - but we need your help.

I additionally request that AHPA consider supplemental funding for bi-state agencies. We do incur additional costs as the following summary notes:

1. We have had to have extra meetings in Minnesota and North Dakota with SHPDA's to arrive at a common plan development process.
2. Our rural area covers over 27,000 square miles -- we have to get out in the field.
3. Time/distance costs for my Board are obviously compounded.
4. Review activities have necessitated extra meetings on 1122 and Certificate of Need (especially in developing new legislation).
5. There is a time loss factor of my minimum staff of five having to be gone so often.
6. Because of the newness and confusion of the legislation we've had significant pressure to attend technical assistance meetings.
7. It is imperative to note, that every agency (regardless of staff size) must meet all of the major items noted in the law and regulations -- not including all the other activities attendant on an HSA.

I appreciate AHPA, and I appreciated your comments at last June's annual meeting. I believe AHPA has the credibility to affect congressional decisions. Anything you can do will be appreciated.

Sincerely,



Donald E. DeMers  
Executive Director

1b

cc: Frank Armstrong  
S.E. Colorado HSA  
Member AHPA Legislative Committee

REVISED

**DRAFT****FOR STUDY/REVIEW ONLY**

1/23/78

POSITION PAPEROFMINIMALLY FUNDED AND RURAL HEALTH SYSTEMS AGENCIES**I. INTRODUCTION**

- A. Rural and minimally funded Health Systems Agencies support the concepts and Congressional intent behind Public Law 93-641 "The National Health Planning and Resources Development Act of 1974." P.L. 93-641 has consolidated efforts from competing Federal programs, improved and built upon the successes and failure of those programs, and extended the concept and functional viability of health planning to the entire country. Among the 200+ Health Systems Agencies across the nation are many small but tenacious organizations grappling with the problems of quality health services, adequate availability and accessibility, while attempting to meet necessary cost containment goals. The following agencies comprise this dedicated group of consumers, providers, and professional staff actively implementing this Law.

West Alabama Health Council, Inc.  
 Gladsen Alabama Health Systems Agency  
 Southeast Alaska Health Systems Agency  
 South Central Health Planning & Development of Anchorage, Alaska  
 Northern Alaska Health Resources Association  
 Navajo Health Systems Agency  
 Arkansas Health Systems Agency  
 South Arkansas Health Systems Agency  
 North Bay Health Systems Agency of Napa, California  
 Region 9 H.S.A. of Crest Hill, Illinois  
 Illowa Health Systems Agency  
 Health Planning Association of Western Kansas  
 Western Maryland Health Systems Agency  
 Health Planning Council of Eastern Shore, Cambridge, Maryland  
 Merrimack Valley Health Planning Council of Lawrence, Massachusetts  
 Northern Michigan Health Systems Agency  
 Upper Peninsula Health Systems Agency, Marquette, Michigan  
 H.S.A. of Western Lake Superior of Duluth, Minnesota  
 Central Minnesota Health Systems Agency  
 Southeastern Minnesota Health Systems Agency  
 Missouri Area 5 H.S.A. Council



Southeast Nebraska Health Systems Agency  
 Greater Nevada Health Systems Agency  
 Health Systems Agency of Clark County of Las Vegas, Nevada  
 NY-Penn Health Systems Agency  
 Western North Dakota Health Systems Agency  
 Agassiz Health Planning Council, East Grand Forks, Minnesota  
 West Central Ohio Health Systems Agency  
 Eastern Oregon Health Systems Agency  
 Keystone Health Systems Agency of Altoona, Pennsylvania  
 West Tennessee Health Association  
 Panhandle Health Systems Agency, Amarillo, Texas  
 South Plains Health Systems Agency of Lubbock, Texas  
 West Texas Health Systems Agency, El Paso, Texas  
 Permian Basin Regional Planning Commission of Midland, Texas  
 Southwest Washington Health Systems Agency  
 Central Washington Health Systems Agency  
 Eastern Washington Health Systems Agency  
 Lake Winnebago Area Health Systems Agency of Oshkosh, Wisconsin  
 New Health Systems Agency of Green Bay, Wisconsin  
 North Central Area Health Planning Association of Wausau, Wisconsin  
 Wyoming Health Systems Agency  
 Western Colorado Health Systems Agency

- B. In facing the serious challenges of P.L. 93-641, the foregoing group has had to struggle not only with the problems indigenous to their areas, conflicting and confusing Department of Health, Education, and Welfare regulations, performance standards criteria and guidelines, but also a serious and crippling lack of adequate funding. Furthermore, many of these agencies serve sparsely populated and immense geographic areas, often with rugged terrain, adverse weather and limited transportation networks.
- Congress has mandated enormous responsibilities for all Health Systems Agencies throughout the country, regardless of their size. However, current funding, which is based primarily on a per capita dollar formula, often penalizes smaller agencies in meeting the health needs of their residents. Notwithstanding the challenges faced, these agencies have had notable successes, not only in meeting Federal guidelines and expectations, but also community needs, in the short timeframe of less than two years.

## II. FUNDING PROBLEMS

- A. A listing of activities mandated by Congress which each Health Systems Agency is required to perform is found in Attachment 1. This list also includes performance standards and expectation levels developed by the Department of Health, Education, and Welfare as a basis for measuring Agency compliance.

It is apparent from this list of activities that the responsibilities of all Health Systems Agencies are enormous. Where this affects the small, minimally funded, and rural Health Systems Agencies to a greater extent is in the capacity to meet these standards with limited staff and resources.

Results of a survey recently taken with respect to the needs of these agencies in meeting the above standards have clearly indicated that, under current funding levels, most of these agencies do not have more than five professional and two clerical staff. The Bureau of Health Planning and Resources Development (BHPRD) currently requires agencies to maintain records and activities in seven distinct functional areas:

- Agency Management
- Plan Development
- Plan Implementation/Project Review
- Plan Implementation/Resources Development
- Data Management
- Coordination
- Public Involvement

Most agencies surveyed estimate that, in order to adequately meet current expectations, a minimum or average of one staff member per function is a prerequisite. Further, many feel that additional staff is necessary to comply with local needs and demands.

It should be noted that Congress has established a minimal funding level of \$175,000 in P.L. 93-641 to accomplish all of these tasks. Unfortunately, the Department of Health, Education, and Welfare interpretation has, for the most part, concluded that this is the maximal funding level for most of the agencies previously listed.

The group asked that the minimal Federal funding level be at least 70¢ per capita with a minimum of \$275,000, including a provision for inflation. Further, the group feels that the Secretary of the Department of Health, Education, and Welfare should be given 5% of the appropriation made under this Act for discretionary use. The Secretary would then have the ability to meet the needs of those agencies which have extraordinary travel needs caused by large geographic areas and/or sparse or widely distributed population, energy, or other growth impacts, multiple jurisdictions such as two state agencies or SHCCS, and other problems.

- B. The agencies presenting this testimony extend across the Nation, North and South, East and West. Many face, as previously indicated, enormous distances, sparse population, difficult terrain, and significant adverse weather conditions. Public Law 93-641 demands public involvement of consumers and providers who are residents of the area in planning for their health. For issues to be discussed and resolved in a democratic manner, adequate provision must be made for insuring participation, involvement, and accountability by and with health service area residents. From the survey, many of the small agencies spend in excess of 10% of their total budgets in Board, Committee and Staff Travel.

(Add Examples)

Involving the public in crucial health planning decisions is, perhaps one of the few rational approaches to the overall cost containment in health services. Comparing agencies covering 40,000 square miles and spending fifteen percent of their budget on travel with those of 400 square miles and spending less than five percent, is a major point that Congress should review and consider after the Oversight Hearings are conducted.

### III. RURAL PROBLEMS

- A. Previous Congressional Reports such as The Economic and Social Condition of Rural America in the 1970's (prepared by the United States Department of Agriculture, December 1971) have found that rural Americans do not share proportionately in programs funded by the Federal Government. Federal spending on Human Resource Development (Education, Health, Welfare, Vocational Rehabilitation, Manpower Training and Development) favors metropolitan counties over rural areas.

Examples are as follows:

- per capita outlays under conditions of pronounced population decline for health services are 4 times greater -- welfare payments 4 times greater -- manpower training and development 3 times greater -- in metropolitan counties than in rural ones;
- rural counties account for 66% of all substandard housing units but receive only 16% of all Federal housing assistance;
- rural counties account for 50% of all children between the ages of 6 and 17 in poverty level families, but receive only 20% of all Federal child welfare service funds -- 24% of Federal aid to families with dependent children -- 26% of Federal headstart and followthrough assistance; and 41% of Federal outlays for elementary and secondary educational programs aimed at meeting the specific needs of disadvantaged children in low income areas.

The entire history of Federal support for local regional health planning has been one of underfunding for rural areas. While 27% of Americans live in rural areas, only 15 to 20% of the health planning money went to the rural areas. Comprehensive health planning for rural areas tended to be done by the State agency rather than by an areawide rural health planning agency.

Although the present health planning legislation provides for total geographical coverage by Health Systems Agencies and a minimum funding level of \$175,000 for less populous agencies, we suggest that health planning in rural areas remains underfunded. A large part of the work of the rural Health Systems Agency is in the Plan Implementation/ Resources Development function, in addition to being concerned with some cost containment issues relating to inappropriate service development. This commitment to resource development should be evident from the correlation between "Critical Health Manpower Shortage Areas" (CHMSA) and "Medical Underserved Areas" (MUA) and the areas covered by rural Health Systems Agencies. Furthermore, the need for making health services

more available and accessible in rural areas has been recognized by Congress, as evidenced by Item (1) of the "National Health Priorities of P.L. 93-641:

"Sec. 1502. The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

"(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas."

Because of the added challenge of resource development (in addition to other problems noted previously), we submit that rural Health Systems Agencies should be funded higher than urban areas. This proposition is as reasonable and logical as understanding that per capita public assistance payments (and many other Federal spending programs) will always be higher in urban areas and attempting a rural-urban equalization for income maintenance (and many other programs) would not be feasible. Increasing the minimum funding base for rural Health Systems Agencies will not only strengthen the implementation of P.L. 93-641 in approximately 40% of the area of the Nation, but it will help to provide necessary resources to planning agencies attempting to ensure the most effective and efficient utilization of resources. Adequate financial support is essential for effective rural health planning which is a requisite for assuring that health care services are available, accessible, and acceptable for all residents of rural areas.

- B. Historically, Federal approaches to health problems have been categorical; most programs have focused on individual groups or populations with specific problems or diseases or special beneficiary status. While we understand there are complex pros and cons concerning categorical programs vs. block formula grants and the revenue sharing approach, the dominance

of categorical programs places a great burden on Health Systems Agencies, especially minimally funded agencies with few staff resources. Health Systems Agency staff must become familiar with hundreds of programs and dozens of personnel in several departments in order to plan and develop resources consistent with legal and other constraints within which these programs must operate. Again, the rural Health Systems Agencies require additional resources in order to relate properly and effectively with Public Health Service Program Chiefs to assure that the allocation of Federal categorical funds are consistent with the Health Systems Plans (HSPs) of Health Systems Agencies. The establishment of these important relationships are obviously more difficult for agencies with severely limited staff resources.

- C. Although P.L. 93-641 was very successful in consolidating the Regional Medical Programs, Comprehensive Health Planning and Health Service Demonstration Projects, there still remains fragmentation of health planning efforts in most health service areas. Planning for implementation of Emergency Medical Service is an example. The insulation of the Federal Veterans Administration and their own internal planning is another. Furthermore, there are many state efforts (often with Federal support) that further fragment health planning in rural areas.

More recognition and support on the part of all Departments and Programs of the Federal and state governments could go a long way to assist rural health planning agencies in acquiring the critical mass necessary to accomplish their planning and development responsibilities.

- D. There are great difficulties for rural Health Systems Agencies in developing an adequate data base. There are a number of factors contributing to this problem. Among them are insufficient assistance

from the Department of Health, Education, and Welfare and most State Health Departments and State Health Planning Department Agencies with present legal restrictions on the collection of primary data in the absence of assistance from other sources. Rural Health Systems Agencies are also dependent upon data from health care providers, such as small rural hospitals, who often do not keep records on such items as discharge diagnosis or, in cases where they do, they are often not uniform with other hospitals in the area. In addition, Health Systems Agencies are held accountable for cost containment but the Federal and State Governments do not disclose or provide adequate financial information that is routinely provided by health care provider groups.

- E. Another concern of the rural Health Systems Agencies are the recently proposed and revised Department of Health, Education, and Welfare Guidelines for Health Planning. The group supports the need for a balanced approach which includes strong health planning, appropriate health service development, and regulation.
- The group supports active participation in the development of cost containment strategies that accurately reflect the unique needs of their Health Service Area residents. It should be recognized that the Guidelines are useful in establishing debate and focusing concern on necessary cost containment initiatives. It should be remembered that the Guidelines are, in fact, only experimental estimates which should serve as guidance but not Law.

#### IV. RURAL HEALTH PLANNING SUCCESSES

- A. Despite the problems, limitations, and constraints under which rural Health Systems Agencies must operate, they have experienced some rather



significant successes. Attached are the positive experiences of \_\_\_\_\_ rural Health Systems Agencies. Their activities are categorized as Resource Development Successes and Cost-Containment Successes.

(Add Examples from Attachment 2)

## ATTACHMENT 1

AGENCY ORGANIZATION AND MANAGEMENT

Establish policies for organization structure, governance, and operation of Agency.

Ensure public notice of all HSA activities and meetings.

Develop and monitor work program and budget.

Establish and maintain internal management reporting system.

Establish and maintain financial administration system.

Develop personnel policies and procedures.

Develop and maintain on an ongoing basis training programs for the Governing Body, staff, committees, Subarea Advisory Councils, etc.

Maintain staff which meets the requirements of the Law.

Main Governing Board which meets the requirements of the Law.

PLAN DEVELOPMENT

Coordinate planning with Federal, state, and local agencies and organizations.

Conduct public hearings on the H.S.P.

Publish and disseminate HSP to area libraries, the SHPDA, SHCC, and other state and local agencies.

Conduct Annual Review of HSP.

Establish procedures and process for Annual Review.

Involve the community in the development of the HSP.

Develop Annual Implementation Plan to describe objectives and priorities to achieve the goals of the HSP.

Ensure notice of AIP availability.

Publish and disseminate AIP to area libraries, SHCC, SHPDA, and other state and local agencies.

Review AIP annually and amend, as necessary.

Identify, collect, and analyze pertinent data  
- health status  
- health system

Establish goals and priorities in the HSP.

PLAN DEVELOPMENT CONTINUED

Identify and analyze the unique needs of the areas population

- manpower
- facilities
- financing

Quantify goals for:

- community health promotion and protection
- prevention and detection
- diagnosis and treatment
- habilitation and rehabilitation
- maintenance
- support services
- enabling services

Address these service categories by settings.

Describe a healthful environment and health system. Address:

- availability
- accessibility
- cost
- acceptability
- continuity
- quality

Considers national and state guidelines and priorities in developing HSP.

Coordinate HSP development with SHPDA, SHCC.

Revise HSP to meet coordination of statewide needs as required by SHCC.

Explain relationship between HSP and AIP and ensure consistency between these two documents.

Prioritize AIP objectives that maximally improve health at least cost.

Seek to implement HSP and AUP.

Publish specific plans and projects for achieving the objectives established in the AIP.

PLAN IMPLEMENTATION/REVIEW ACTIVITIES AND HEALTH SYSTEM DEVELOPMENT

Develop criteria and procedures regarding evaluation of need for:

- modernization, construction, and conversion of medical facilities
- other plan facilitation activities
- new institutional health services
- appropriateness review
- certificate of need review
- Section 1122 review
- other plan implementation activities
- PUFF

- Area Health Service Development Funds

Review the need for new institutional health services and make recommendations to the State Agency.

Review on a periodic basis (at least every five years) all institutional health services and make recommendations to the State Agency regarding the appropriateness of such services.

Annually recommend to the Secretary of DHEW and State Agency:

- A. Projects for modernization, construction, and conversion of medical facilities.
- B. Priorities among such projects.

Review and approve or disapprove or review and comment upon as appropriate . . . each specified Proposed Use of Federal Funds within the Health Service Area.

Identify relationship between health status and health system goals.

Spell out long range recommended actions and resource requirements or implications in terms of manpower, facilities, equipment, and financial impact.

Develop procedures and policies for conflict of interest in Project Review.

Establish coordination between HSA and other agencies engaged in concurrent review of projects.

Establish policies, procedures, activities to ensure public involvement.

Provide consultation and technical assistance to prospective applicants in the preparation of proposals for review and other projects and programs which meet the objectives and priorities of the HSP and AIP.

Develop a monitoring and tracking system to assure that timely information is available on reviews.

Establish a post-review system to insure execution of projects as approved.

Maintain data on applications and/or consultations.

Develop Memoranda of Understanding with SHPDA, A-95 Clearinghouses.

HSA involvement in local, state, and national issues concerning health status of area residents and health system in area.

Make grants and enter into contracts with public and non-profit entities to assist them in planning and developing projects and programs which will achieve the objectives of the HSP.

DATA MANAGEMENT AND ANALYSIS

Identify, collect, and analyze data concerning:

- health status of area residents
- status of health care delivery system and use by residents
- effect of system on residents
- number, type, and location of area resources
- patterns of utilization of the area's health resources
- environmental and occupational exposure factors affecting immediate and long term health conditions

Develop policies, procedures, and systems for organizing, storing and retrieving information of the above types.

Coordinate data acquisition and analysis with the Cooperative Health Statistics System (CHSS), through an agreement with the CHSS, SHPDA, PSROs, other HSAs, A-95 Agencies, and other appropriate Federal, state and local agencies.

COORDINATION

Develop, adopt, and implement written agreements for the coordination of HSA activities with PSROs and A-95 Agencies in the area.

Coordinate in the areas of data, review, and input of documents, technical assistance, and implementation.

Coordinate activities with other Federal, state, and local entities.

PUBLIC INVOLVEMENT & EDUCATION

Develop and adopt procedures for public information and education regarding HSA functions and responsibilities.

Establish policies and procedures regarding public review and inspection of Agency documents, records, and data.

Ensure adequate notice of all meetings and hearings.

Develop an annual report concerning the activities of the Agency.

Develop and adopt policies and procedures for receiving public input on Agency functions and activities.

Develop, maintain, and make available for public inspection and copying, an index of the records and data of the Agency.

Develop strategies and programs for educating area residents about personal health care and services.

Provide each Indian Tribe which is located within its Health Service Area information respecting the availability of Federal Funds.

Mr. ROGERS. Thank you very much. We appreciate you in being here.

Mr. Preyer.

Mr. PREYER. I thank you, too, and I think you have given us an eloquent statement of bottoms-up planning which will be very helpful.

Mr. ROGERS. Thank you so much.

The next witness is another distinguished colleague of ours, the Honorable Gary Meyers from the State of Pennsylvania.

We welcome you to the committee and will be pleased to have your statement. It will be made a part of the record at this point and you may proceed.

#### STATEMENT OF HON. GARY A. MYERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. MYERS. Thank you, Mr. Chairman.

I appreciate the opportunity to appear here today and share briefly with the subcommittee some of my views on the health planning process. I will deviate from my prepared remarks and compliment you for honoring the commitment you have made on the floor of the House and to a number of us that you would provide the opportunity for input such as this.

We have had an active HSA in southwestern Pennsylvania and a great deal of public participation in a sometimes volatile health planning process. The views I will express are based on my observations of and participation in that process.

I realize the subcommittee has before it both subcommittee and administration bills proposing far-reaching changes in HSA structure and process, as well as recently altered HEW national health planning guidelines. While I may wish to comment on specific provisions of those bills or those guidelines in the future, I want to take this opportunity to share with you several overall principles which I believe should guide the subcommittee as it considers the important issues facing it.

The first principle that should guide health planning policy, in my opinion, is to keep decisionmaking as close as possible to the people. I know I am not telling the subcommittee something it has not heard before when I say that citizens in communities across the Nation are the individuals who build and who maintain community hospitals. Federal and State assistance has helped, but by and large it is local citizens who have raised the funds, issued the bonds and attracted the doctors. And, with all due regard to the need for regional health planning, it is these local citizens who should have the greatest say in decisions about providing health services.

This principle of local control is worth repeating as the subcommittee considers whether the locus of power in the planning process should be at the HSA, State or Federal level. I believe it should be underscored and it must be remembered as the subcommittee considers HSA composition issues.

Transferring power too far from the hands of local citizens or creating nonrepresentative boards can alienate citizens and com-



munities from the health planning process. Even now, many citizens in western Pennsylvania tend to view our HSA not as a local agency—as it is seen from Washington—but as a long arm of the Federal Government. And transferring decisionmaking power from localities can unfortunately destroy one of our Nation's most vital health resources: local interest in and support of community health facilities. While this local interest and support is not conventionally listed among "health resources," I submit that it far exceeds in importance very CAT scanner in the Nation. Once again, I urge the subcommittee to keep health planning as close as possible to the people.

A second principle that should guide Federal health planning decisions, in my estimation, is maximum flexibility both at the HSA level and at the sub-HSA level. There may be a time in the future when health planning techniques are sufficiently sophisticated and assured of bringing results so as to argue for rigid guidelines. Now, though, when health planning is still in its infancy, excessively rigid health system plans, certificate of need, or appropriateness review procedures serve only to alienate citizens and to achieve a nonproductive "leveling" effect.

I believe, at this state of health planning sophistication, that community medical facilities should be given considerable flexibility, and should be encouraged to comply with regional health plans rather than being forbidden to deviate from a prescribed system. Medical facilities not complying with HSA plans could be penalized through the medicare reimbursement system, for example, so that they lose that part of the reimbursement amount attributable to noncompliance facilities or services.

But there should be no absolute ban on providing services for which a local community is willing to pay a premium out of its own pockets. There should not be, in my estimation, federally supported groups telling local communities they absolutely cannot try harder and provide services above a mandated level.

Finally, Mr. Chairman, I would suggest as a third principle guiding the health planning process noninvolvement by HSA's in social or moral issues peripheral to the health planning process. This is an area, Mr. Chairman, where I respectfully suggest the subcommittee may wish to provide guidance to HSA's.

I do not believe, for example, that the issue of appropriateness of abortion should affect HSA health planning policies. Normally, I would not have even considered raising the abortion controversy in the context of health planning. However, the issue has already been raised in western Pennsylvania—and, I understand, in other areas of the Nation—since the HSA of southwestern Pennsylvania board passed a resolution supporting medicaid-funded abortions.

I am not interested in limiting the free speech of citizens serving on HSA boards. But the resolution to which I refer has caused considerable concern among pro-life groups in my district—justifiable concern, I believe—that the HSA board's personal views on controversial social and moral issues will color the health planning process.

Regardless of whether one feels formal health planning will work or not, I believe there is a consensus that planning should be attempted on a rational, nonemotional basis. Interjecting controversial



topics like abortion rights into the debate can only further complicate the planning process. Once again, I urge the subcommittee to offer guidance to HEW to guard against permitting HSA involvement in social and moral issues.

Thank you again for the opportunity to appear here today, Mr. Chairman. I appreciate the subcommittee's consideration of my remarks.

I would also like to just briefly underscore what Congressman Stangeland pointed out. He had examples of local hospitals whose costs ran significantly below the national average. We had a community in our area where the hospital administrators could prove that the HSA was attempting to phase out a facility that was providing hospital care at a cost substantially below that at the facility to which the citizens would be diverted. It is not true that formal planning is correct in all cases. That is why I think flexibility should be made in all areas that it can be provided.

Mr. ROGERS. Thank you. Your suggestions are helpful to the committee and will be carefully examined.

Mr. PREYER. I share your views about the noninvolvement of HSA's in social and moral issues. I think that will handicap the planning process. I wonder what kind of guidance we can give on that without interfering with their local autonomy and perhaps constitutional freedom of speech issue?

Mr. MYERS. As I understand it, there are lobbying prohibitions currently in law that address the use of Federal funds. I think we should look at whatever way we can broaden that where the activities concern HSA's. I think the HSA board members have the right as individuals to take positions on social and moral issues. But as a body to pass a resolution which then may affect their decision to close one hospital which might have a service which perhaps might not be consistent with their moral values would, I think, cause a very difficult situation in the community and actually erode the confidence that health planning had been done on a basis absent of that particular bias.

I think the committee can in fact include strong language which would specifically point out the intent of Congress that we don't expect the bodies to embroil themselves in these social issues unless they are relevant to the mandate of planning that has been given to them and I think, within that mandate, there should be sufficient flexibility for them to express their personal opinions.

Mr. PREYER. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I would like to congratulate the gentleman from Pennsylvania.

You have a broad spectrum of citizens from every level of society in your HSA.

Mr. MYERS. I guess it would depend on who you ask. If you ask the HSA membership, they probably think they have a broad spectrum. If you ask the individual citizens affected by the HSA decisions, there is currently a feeling that there is not a representative level of communities and, quite frankly, I think the process by

which individuals are elected to HSA boards is so well hidden that the average participant in the community really does not know how to prepare himself to become a member. I am not speaking of immediately becoming a member, but to prepare himself in his plans to become a member sometime in the future.

I think there is not, from my observation, a cross-section, sufficient cross section represented in the agency.

Mr. CARTER. At the present time approximately 15 percent of the membership throughout the country is composed of elected officials, I believe. Do you think that is sufficient or should there be more, or less? Should they be classified as providers or consumers?

Mr. MYERS. That is a difficult question because I think there could be attempts by elected officials to utilize their membership on an HSA board to enhance their other political aspirations. I think that is a risk that should not be ignored.

I don't think that we can accept the theory that simply because somebody has been elected as a Member of Congress or a member of the legislature of a State or as a city councilman that he is best qualified to serve on a health planning board.

I am not sure that that is all that is necessary. I think whatever the board's makeup is, that certainly one of their responsibilities is to consider the opinions of people who have been elected in the communities. This can be done through the hearing process by permitting an adequate interface between the two bodies.

Mr. CARTER. I want to thank the distinguished gentleman for his excellent statement.

Mr. MYERS. Thank you, Dr. Carter. I appreciate your interest and the subcommittee's interest.

Mr. ROGERS. Thank you for your help.

Without objection, the Chair wishes to place in the record, as though read, the statements of Congressman Stewart B. McKinney of Connecticut and Hon. Baltasar Corrada, Resident Commissioner, Puerto Rico.

[Statements of Congressman Stewart B. McKinney and Hon. Baltasar Corrada, Resident Commissioner, Puerto Rico, follow:]

#### **STATEMENT OF HON. STEWART B. MCKINNEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT**

Mr. MCKINNEY. Mr. Chairman and committee members: I value this opportunity to offer the committee some first-hand insight into the failure of HEW to properly administer the regional health systems program. I must also urge the committee to review and clarify certain existing provisions under Public Law 93-641 and Public Law 95-215, before further granting the regional HSA's the power to decertify certain medical facilities. I have personally witnessed, Mr. Chairman, the controversy, anger and harm that can result from misinterpretations of existing law. HEW has interpreted its power to grant an extension of temporary designation for a Health Systems Agency [HSA] one way, the public has interpreted its right to a meaningful public comment period in another way. Hence,

before the national program for the establishment of regional health plans proceeds much further, this committee must clarify the Agency's power, the public's right to involvement and HEW's responsibility to respond to public concern.

I recently became involved in a matter regarding the proposed health systems plan [HSP] for Fairfield County, Conn. As a result of the overwhelming public concern in Fairfield County regarding the future possibility of decertifying certain hospital units, the lack of available information regarding the HSP's regional, economic impact, and the insufficient opportunity for full public comment, I solicited the assistance of both the HEW regional office in Boston and Secretary Joseph Califano. In both instances I requested that the fast-approaching deadline for submission of the Southwestern Connecticut Health Systems Agency's application for permanent designation be delayed for just 90 days in order to allow the public's overwhelming concern every opportunity to be fully expressed. It was not until I received the Secretary's official response to my request for extension, that I realized how harmful HEW's misinterpretation of existing law could be to the future of all H.S.A. programs in the country. It was also as a result of this response that I realized the importance of this committee's task in clarifying existing provisions to correct H.E.W.'s misinterpretation, and thereby mollify the public's legitimate concern that future plans will be arbitrarily forced upon them. Let me explain in more detail.

As a result of the controversy and inordinate public interest by Fairfield County resident's concerning the content of the proposed HSP. I sent Secretary Califano a letter outlining those concerns. [insert No. 1, see p. 913].

Unfortunately, Mr. Chairman, the Secretary's response not only lacked cognizance of the dilemma facing Fairfield County (as outlined in my letter), it also demonstrated an insensitivity to the public concern and an astonishing lack of knowledge of the language of the enabling legislation. Insert No. 2 [see p. 916] is the response bearing the secretary's signature.

Clearly the Secretary's response was inaccurate. The exact wording of Pub. L. 92-215 states:

The Secretary may upon application of a conditionally designated entity, extend for an additional period of not to exceed 12 months the period of such entity's conditional designation if the Secretary determines that (A) unusual circumstances exist. . . .

The conference report accompanying Pub. L. 95-215 (House Report 95-828), to which the Secretary refers in his letter, states:

Such circumstances which might cause the Secretary to make such a determination include *but are by no means limited to* (emphasis added) the following: —Agencies serving areas that in whole or in large part have had to devote a greater portion of their effort and resources in the first 2 years to organizational development, community involvement . . .

There is a clear contradiction between the Secretary's interpretation of the criterion needed to extend a programs' conditional designation and the conference reports interpretations of those same criteria. The Secretary's letter refers to a "rather specific list" of



unusual circumstances under which an extension would be granted. However, the conference report states that those unusual circumstances, including "community involvement", are by no means limited to that which the report lists. Furthermore, the Secretary's perfunctory reference to the need for public involvement does not do justice to the importance of public involvement in the ultimate success of a regional plan. Nor does his letter demonstrate a legitimate effort on the part of H.E.W. to become familiar with the situation in Fairfield County. Will this misinterpretation of the legislative intent of the law also prevail when citizens are faced with the more serious questions such as decertifying local medical facilities. H.E.W. has requested this committee to grant H.S.A.'s the power to decertify and I think the committee should take a long look at the quality of the administration of existing statutes before granting further powers under Pub. L. 93-641.

Lest any of the committee members incorrectly believe that the public concern in Fairfield County, to which I refer, is merely the uninformed protestations of some local politician, let me recount for the record the following facts.

The HSP for Fairfield County was first released to the public on Dec. 19, 1977 with the vote for final approval scheduled for February 7. At each of the four public hearings held to consider the plan—Jan. 25, 26, 27, and Feb. 2, 1978—well over 200 people attended. In fact, as mentioned in my letter to Mr. Califano, one meeting was closed because the number of attendees exceeded the legal capacity of the meeting hall. The groups in attendance represented diverse interests within the community, however, there was no question as to the commonality of their goal—an extension of time for meaningful public involvement in the plan. In addition to those attending the meetings, several groups in Fairfield County presented their criticism in well-documented written statements, which were submitted to the Southwestern Connecticut H.S.A. By way of example, a critique was submitted to the H.S.A. by the Stamford Area Commerce and Industry Association [see insert No. 3, p. 917].

Furthermore, Mr. Chairman, in response to the community's concerns, the governing board of the region's H.S.A. stated their willingness to participate in workshops in an effort to resolve any differences that might exist concerning the programs goals. Both the sponsors of the program and its critics were in contact with my office and the H.E.W. regional office in Boston. Clearly, a 90-day extension for public comment—which would have been obtained by a better understanding by H.E.W. of the criterion for that extension—would have insured a successful mandate for the regional health plan in Fairfield County. As it stands right now, Mr. Chairman, the public has been frustrated in their attempts to contribute and shape the program to their particular needs. They are concerned that H.E.W.'s apparent misinterpretation of the law as it pertains to extensions, may be an indication of future uncertainties that could result in the decertification of local medical facilities. They now view this well intended program as one more example of arbitrary, government intervention in their lives.

It is indeed an unfortunate situation. Hopefully it is one that this committee can rectify. I would urge the committee to review the provisions dealing not only with the laws regarding extensions of conditional designation, but with any provisions which might allow the public more meaningful participation in the development of their regional health plan. Furthermore, Mr. Chairman, I would urge the committee to scrutinize the potential for misinterpretation in any additional provisions to the law, especially those concerning decertification. Any further mandate to Pub. L. 93-641 must include clear and unmistakable guidelines for the implementation of its goals.

[Testimony resumes on p. 926.]

[The attachments referred to follow:]

STEWART B. MCKINNEY  
4TH DISTRICT, CONNECTICUT

106 CANNON HOUSE OFFICE BUILDING

COMMITTEES:  
BANKING, FINANCE AND  
URBAN AFFAIRS  
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**Congress of the United States**  
**House of Representatives**  
**Washington, D.C. 20515**

February 2, 1978

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The Honorable Joseph A. Califano  
Secretary  
H.E.W.  
200 Independence Avenue, S.W.  
Room 615F  
Washington, D.C. 20201

**INSERT**  
**# 1**

Dear Mr. Secretary:

I am writing you in behalf of hundreds of Fairfield County, Connecticut citizens who are interested, as I am, in implementing the most equitable and effective regional health systems plan possible. The concerned citizenry of our area is convinced that the only means by which to insure the implementation of an effective plan is through an extension of the program's deadline for the filing of an application for permanent designation. Your commitment to grant such an extension would allow a continuation of the overwhelming public interest in this program and would assure the public that its concern will not go unheeded.

Pursuant to Public Law 93-641 the Southwestern Connecticut Health Systems Agency must submit an application for permanent designation on February 13th, to the Department of H.E.W.'s Region I office in Boston. In recent weeks, upon completion of its Health Systems Plan, the agency has conducted three public hearings to illicit community comment on the proposal. At each of these meetings several hundred concerned community residents have been in attendance. In one instance, the attendance of over 500 people resulted in the cancellation of the meeting by the local fire marshall's office. Represented at each of these gatherings have been hospital administrators, consumer groups, industry and commerce executives, anti-abortion groups, and members of the medical community. The commonality of their concern belies the diversity of the groups interests and as such, provides a clear indication that further opportunity for community involvement is warranted. In fact, this relatively cohesive effort by so many varied interests constitutes both the problem and the potential solution for which I am requesting your assistance.

Since its publication, the proposed H.S.P. for the Southwestern Connecticut region has been subject to a great deal of criticism. Despite the strength of the complaints, however, I do not believe the program's critics wish the elimination of the regional agency or its function. Rather, these interested groups would like to continue their analysis of the program and work with the H.S.A. to implement the best plan for our region. Similarly, the governing board of our region's H.S.A. has expressed a willingness to work with the public in meeting that goal. They are,



however, understandably concerned that requesting an extension of the public review period, instead of filing an application for permanent designation by February 13th, may result in the rejection of the extension request and thus result in the termination of the agency and its two-year effort.

With the gracious cooperation of Mr. Robert Watson, the regional director of H.E.W.'s Boston office, I have become familiar with the process for reviewing applications for extension. It is my understanding that an extension is granted if "unusual circumstances" prevent the effective completion of the program within the specified time period. Given the uncertainty of the determinants in that review process, I can readily understand the governing boards reluctance to file for an extension. However, the unprecedented public interest in the development of an H.S.P. for this region, and the willingness of all-concerned to cooperate in workshops and other mechanisms for an effective program, has convinced me that an extension is well deserved and should be requested. As is the case with many federal programs the success or failure of the National Health Planning and Resource Development Program will depend on public interest and cooperation. In this particular instance, the success of the program may well be decided by granting the public 90 more days to actively participate.

Your direct intervention in this matter, Mr. Secretary, is needed to assure the governing board that the product of their two year effort will not be jeopardized by the rejection of their 90-day extension request. The board will meet on February 7th to vote either for an application for extension or permanent designation. I would like at that time to be able to give them your written assurance that their extension request will be granted without the loss of the agency.

Furthermore, Mr. Secretary, the public's overwhelming interest in this important health program should not go unrecognized or unrewarded. Anytime the federal government can get as many people actively interested in a federally initiated effort, it should jump at the opportunity to allow the public's involvement to continue unhindered. Granting a 90-day extension for further community involvement in this matter will assure a successful mandate for the program. To deny such a request will certainly result in a lack of community cooperation and will discourage the residents of Fairfield County, Connecticut from further involving themselves in other federal initiatives.

I respectfully urge you, Mr. Secretary, to intervene in behalf of Fairfield County and grant an unqualified 90-day extension. As previously stated, I would like to present to the board, prior to their February 7th meeting, your written commitment for extending the necessary deadlines. I very much appreciate your kind assistance in this matter, and I await your positive reply.

Sincerely,

Stewart B. McKinney, M.C.

SBM:hs



THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE  
WASHINGTON, D.C. 20201

FEB 8 1978

INSERT  
# 2

The Honorable Stewart B. McKinney  
House of Representatives  
Washington, D.C. 20515.

Dear Mr. McKinney:

Thank you for your letter of February 2 in which you urge me to assure the governing body of the Southwestern Connecticut Health Systems Agency that if they apply for an additional 90 days of conditional designation their request will be granted. I regret that I am unable to grant your request.

We were granted the authority to allow extensions of conditional designation in Public Law 95-215, but only in instances in which unusual circumstances prevail. The Conference Committee report that accompanied that Act provided a rather specific list of unusual circumstances. In our own recent policy guidance to the Health Systems Agencies we have stayed very close to the language of the Conference Committee report. Our Boston Regional Office staff report to us that the circumstances necessary to grant a waiver do not appear to be present in this situation, although it is impossible to make a definitive determination in the absence of a formal and detailed request by the Health Systems Agency--the only body empowered to seek a waiver.

I share your concern for the need for substantial public involvement in the process of establishing health systems plans. Our Boston Regional Office reassured me that while the public hearing of the 26th of January was cancelled, as you indicated, it was replaced by two additional public hearings which were held on January 28 and February 2.

I hope this information is helpful to you. If we can be of further assistance, please contact us.

Sincerely,

  
Joseph A. Califano, Jr.

INSERT  
# 3

STATEMENT ON

REGIONAL HEALTH SYSTEMS PLAN

Submitted by  
Stamford Area Commerce & Industry Association, Inc.  
to Southwestern Connecticut Health Systems Agency  
at Public Hearing  
Thursday, January 25, 1978  
Davenport Ridge School, Stamford, Conn.

Good evening. I am E. Gordon Goodlett, Director of Regional Development for the Stamford Area Commerce & Industry Association -- SACIA.

SACIA represents over 350 businesses located in the eight-town region as identified by the Southwestern Regional Planning Agency (SWRPA). Its membership includes most of the major Fortune 500 companies which have located in this region over the past decade. It also includes virtually every major company in each of the principle business classifications represented in this region -- manufacturing, finance, retail, service, and professional. However, more than 80% of its membership is what would generally be considered "small business" -- i.e., 100 employees or less.

SACIA subscribes to the belief that there are a number of "quality of life" issues affecting the region that can best be addressed on a regional basis. They include transportation, housing, highway development and, of course, health systems management. We generally support truly comprehensive, rational, and sound regional planning as being essential to maintaining and enhancing the region's quality of life.

Business has a major stake in the proposed health system plan because it pays millions of dollars for employee health insurance plans and industrial health facilities which, conceivably, could be affected by the implementation plan for the next five years.

The purpose of the plan, as we understand it, is "the achievement of equal

access to quality health care at a reasonable cost." This is a laudable goal. And, we have no quarrel with it. As much as the average citizen, business also is concerned with the rising costs of health care services and the quality of care. A recent survey of the SACIA membership indicated that 80% of those members responding considered rising health care costs to be either "important" or "very important."

This agency realizes, we are sure, that a large part of the health care costs are paid by third party insurers, of which business is a significant part. The costs of insurance premiums is often borne either fully, or in large part, by businesses or their employees and, in many cases, their families. So, business firms have a direct economic stake in higher health care costs through higher premiums. There is a further impact resulting from time lost from employees for health related reasons which is immeasurable. Nonetheless, it is significant and of concern to all employers.

We acknowledge the work put into the development of this report by your Agency through its task forces and sub-task forces. We have several major reservations regarding both procedures and conclusions. However, it does not diminish our respect for your efforts.

Nevertheless, our primary recommendation is that the Board of the Regional Health System Agency not immediately adopt this report. In fact, we may eventually urge that you not adopt it at all in its present form.

We make this recommendation for the following reasons:

First, the report -- its findings, conclusions and recommendations -- is massive and highly complex and technical. The 470-page report was made available



only within the past month.

It took 18 months to prepare the report. To expect the average citizen -- or even individuals or organizations who have more than average resources to undertake evaluation of the report -- to be able to evaluate and understand the report fully and intelligently is unfair and totally unrealistic.

We understand that the Agency is pushing final approval of the plan so it can realize its designation by the Health, Education and Welfare Department as the official regional Health Systems Agency. We believe that this rush to judgment or final approval is unwise over the long run. Inadequate, incomplete or erroneous understanding of the report and its recommendations for the sake of official Agency designation by HEW will be counterproductive to the Agency's ability to achieve the plan's objectives and goals.

Second, there is wide spread misunderstanding regarding exactly what this report says or means. We certainly appreciate the fact that you are conducting a series of public hearings on the plan. However, we believe they are inadequate -- again considering the lengthy preparation time for it and its complexity. The highly publicized disagreement over what this report says or does not say extends to the area professional medical community, citizen groups, and even, we note, to members of the Board of this agency who have been publically quoted disagreeing over interpretations of the plan's recommendation. Meaningful and constructive understanding of the plan is difficult, if not impossible, if the various affected parties cannot agree on what the plan proposes or does not propose.

Over the past month or so, the reported disagreements, contradictions, and lack of adequate clarification has served to confuse, rather than enlighten the public on the intent and merits of the plan.

To compliment our initial recommendation, we further recommend that no final action be taken on the plan until a series of community workshops be held at which the plan would be thoroughly explained, analyzed and discussed. Recently, a year long study on Stamford's arts resources and needs was completed. It certainly was not as complex as your report. Nonetheless, it held a series of four community workshops to explain the report's recommendations and get public support for it -- which it got. We believe it essential that this be done with this report because of its very serious implications to the health care delivery system for the region and its people. As the May 1, 1977 Connecticut edition of the New York Times noted in an article on this issue: "At stake is the autonomy of the area's 17 institutions, the prerogatives and traditional independence of its 1,200 physicians, the interests of the area's 635,000 residents as represented by a handful of the agency, selected consumer advocates..."

We are also troubled by an apparent lack of input from significant elements of the region, which will be drastically affected by the plans you propose. It was unrealistic not to include them in the planning process.

For example, we have discerned very little reference to participation by the region's business community which, as we noted, has a great stake in the plan.

Had the major employers of the region been approached or contacted business organizations like SACIA? To our knowledge, there is very little awareness by them of your agency and its grand plan for the region. No one approached us. Or, any of our members, as far as we have been able to determine, to seek their reactions or to evaluate the action plans and goals as they were being developed. We do not accept the minimal representation on the Task Forces by business as being adequate.

Your action plans -- particularly in the areas of Environmental Quality and OSHA-- could have profound effects on business. Yet, we see no evidence that... consideration was given to this impact in developing your plans. In fact, we perceive a disturbing lack of such analysis, or foresight. The overall priority, we have come to believe, was to complete the plan for approval and secure an agency designation -- at any cost.

We do not possess any great competency to discuss many of the medical aspects of your recommendation. Given the little amount of time we have had this report, the lack of community workshops, and the apparent disagreement, we do not feel capable of analyzing its medical contents.

There are two areas, at least, however, where we do believe we possess the requisite background and experience to comment. What we see in these areas does little to reassure us with regard to the whole report. I refer specifically to the sections on Environmental Quality and OSHA.

In the area of environmental quality, we find it difficult to argue with the basic goals. Your report correctly points out that there are problems in the region. It would be equally difficult to argue with either your facts or your conclusions. However, we find the report to be simplistic, unrealistic and, quite frankly, somewhat naive. It appears to be a condensation of other much more detailed reports. In our opinion, the long-range actions you propose will not meet the Plan's long-range objectives. The report makes some very casual references to solutions which are not all that simple to achieve.

For example, you promote the recommendations of the Connecticut Lung Association for reducing transportation-related hydrocarbons. Yet, the report almost totally ignores all of the problems being experienced by the Connecticut Department of Environmental Protection and the Federal EPA in promulgating a Connecticut Transportation Control Plan for reducing hydro-carbon emissions. You talk about seeking cooperation between health planning agencies and other planning agencies in New York, New Jersey and Connecticut as a way to reduce inter-state flux. This ignores the fact that Connecticut has actually been forced to consider suing New York to achieve cooperation. The report speaks in glowing terms of the Connecticut Resource Recovery Agency, yet, it ignores the fact that the construction completion deadline has recently been pushed into 1979 and final operation will be far beyond that -- perhaps even beyond the reaches of your five year plan.

We can agree with your long-range goals in Environmental Quality. However,

we are quite skeptical regarding the ability of your group to achieve them, especially through the so-called long-range plans outlined.

We also make it quite clear that our willingness to agree to the basic objectives does not automatically indicate our assent to some of the plans you suggest as solutions.

As far as OSHA is concerned, we are forced to conclude that your report really doesn't say anything nor does it make any realistic proposals. The report virtually ignores -- or even negates -- economics. You seem to have no perception of how much it costs to do something. Nor does it reflect an understanding of the needs of employers under this law -- the same employers who provide the jobs, payrolls, and other economic benefits essential to the economic health of the region.

The only concrete action you propose relative to OSHA -- other than trying to gain access to now-confidential documents and the development of training programs is to create in 1979 a task force to undertake studies. No indication is given as to who would be on this task force, its mission or its method of operation.

In the long range objectives for Ambulatory Care -- on page 93 -- of the Summary Plan, the report implies that "by 1982 a regional system of public transportation" would exist as a means of mass transit for the elderly and handicapped persons. A very noble thought. However, public and private agencies, including SWRPA and SACIA, have been working diligently yet frustratingly to bring about regional transportation systems. The Connecticut General Assembly and the State

Department of Transportation have tried -- without much success to date. You just don't wish a regional transportation system into place -- as ideal as the objective is, which we happen to share.

Other sections of the report take on the appearance of being a "wish" book, with apparently little understanding of the complexities and difficulties in realizing these "wishes."

If the rest of this report produces as many concerns and questions in other minds as these sections cause in ours, we caution you against its acceptance. In fact, we urge a delay of 60 to 90 days to allow for a constructive dialogue on the report, from which better understanding and agreement could come.

Let me close by saying that, if this Board agrees with our conclusions, that it would be premature to accept this report at this time, we would stand ready to assist you in whatever way we can in communicating and explaining this plan to the broad community...not in a "public hearing" format with all its limitations, but in a true two-way dialogue that will result in a plan that works well for everyone.



**STATEMENT OF HON. BALTASAR CORRADA, RESIDENT  
COMMISSIONER, PUERTO RICO**

Mr. CORRADA. Mr. Chairman and members of the subcommittee, it is a pleasure for me to be able to testify on H.R. 10460 and particularly in support of my bill H.R. 10418.

This bill is a simple one and would provide for the inclusion of Puerto Rico in section 1536(a) of the Public Health Service Act. The only thing this will do is make Puerto Rico a single area state for the purposes of the act.

Mr. Chairman, as I have previously written to you, the Government of Puerto Rico runs a very extensive public health service which provides health care to over 1.4 million persons or about half of our population. In order to do this, the Puerto Rico Department of Health has a very well staffed planning unit, which in many cases duplicates the work of the present HSA. In fact, the HSA's jurisdiction is identical to the Department of Health's planning unit, which is the local SHPDA. This produces a situation of overlapping responsibilities, duplication of efforts and wasted resources, time and funds, and both agencies are constantly interfering with each other's efforts to carry out their respective functions.

The SHPDA's resources were diminished by recent legislation and therefore, it is now short-handed in spite of having greater responsibilities. The HSA on the other hand, is over endowed with funds. The HSA does not recognize the SHPDA's role in health planning, as it (the HSA) feels it has the authority to carry out its plans regardless of the SHPDA's opinion.

As you can see, Mr. Chairman, this creates a serious problem for a government for which health planning has always been a question of public policy. Having an HSA that does not agree with the programs and philosophies of the Government can create serious disruptions in our health care delivery system.

Pub. L. 93-641—the Health Planning Act—was designed for the type of health care delivery system which predominates in the states and not for Puerto Rico, where as I have said before, the Government directly provides health care for about half of the population, particularly the medically indigent.

Our Government's considerably larger role in providing health services to the community demands that it have the authority to design and implement its own plans. As a matter of fact, the Puerto Rico Department of Health is quite capable of performing this task faster and at a much lower cost than the present HSA.

On the question of community participation, I would like to point out that a law recently enacted by the Puerto Rico legislature regarding health planning in Puerto Rico mandates and safeguards community participation in all aspects of the health planning process. The Government has every intention of promoting genuine and effective community participation in the process to the fullest extent possible.

Mr. Chairman, I would now like to briefly enumerate what we envision would be the benefits accruing to health planning in Puerto Rico if the provisions contained in my bill are enacted:

First. The Puerto Rico Health Department information system could be greatly improved.

Second. Health planning manpower could be better distributed throughout the island, since the Department has a highly developed regional organization.

Third. The entire planning process would be accelerated.

Fourth. The cost to both the Federal and State government would be greatly reduced, since having a single agency would mean cutting over-head and administrative expenses at least by half.

Fifth. The Health Department's internal short-term planning and program needs would be better served. This would result in improved health services to the majority of the Puerto Rican people.

I believe, Mr. Chairman, that these are very sound reasons for my proposal and I hope that the subcommittee will agree with me that everyone would be better served at a reduced cost to the Federal Government.

I hope that you and the subcommittee members will support my bill.

Mr. ROGERS. The next witness will be a panel of hospital representatives, Mr. John Alexander McMahon, who is president of American Hospital Association; Dr. Leo J. Gehrig, senior vice president of the American Hospital Association; and Michael D. Bromberg, executive director of the Federation of American Hospitals, accompanied by Mr. Robert J. Samsel, president of the Federation of American Hospitals.

We welcome you gentlemen. It might be helpful if you could highlight the major points you think we should hear. Your full statements will appear in the record.

**STATEMENTS OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT, AND PAUL W. EARLE, VICE PRESIDENT; AND MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, ACCOMPANIED BY ROBERT J. SAMSEL, PRESIDENT**

Mr. McMAHON. Thank you, Mr. Chairman.

Mr. Chairman, I am John Alexander McMahon, president of the American Hospital Association.

With me today are Leo J. Gehrig, M.D., senior vice president, and Paul W. Earle, vice president, of the Association.

We supported, as indicated in our statement [see p. —], the original planning law and the extension now before the committee.

We have some amendments to suggest to the planning law itself. They are found from pages 3 to 12 and then we have comments on your bill H.R. 10460. Those comments begin on page 12 and go to page 19.

We mention on page 3, Mr. Chairman, the voluntary cost containment effort, the fact that hospitals and physicians are concerned about the rate of increase in hospital costs and that it is exceeding the gross national product. We mention there the joint effort of the

AMA, the Federation of American Hospitals and, of course, our own activities. We will be keeping the committee in touch with those voluntary efforts as we have already and will be glad to respond to any questions if you have them.

Mr. Chairman, I would like to address myself specifically to four areas which we think ought to be touched on in the extension process and, of course, we could explore any others the committee would be interested in.

On page 4 we expressed our concern about the national guidelines for health planning because we believe that national guidelines should serve as a flexible guide to the development of local health plans and objectives. Mandatory Federal guidelines imposed uniformly on each HSA and in each State, with modifications only through a cumbersome exceptions process—as previously proposed by HEW in regulations—would prevent the development of viable health service plans adapted to local needs.

We have mentioned in our testimony the need to clarify the guidelines and the relationship between local and national authorities and in the attachment to our testimony we set forth a specific amendment which we think would clarify the confusion that exists and clarify the attempts, on occasion, of HEW to move farther than it should.

On page 5, Mr. Chairman, we have mentioned an amendment to expand the scope of the requirement for State certificate of need to encompass health capital expenditures without regard to ownership or location. We believe that the private offices of health practitioners should be subject to CON review to the extent those offices are proposing to obtain highly specialized equipment or develop facilities typically provided in an institutional setting.

We set forth in the testimony as an example the CAT scanner situation, and we mention specifically the amendment that we have proposed that would also apply to such activities as health maintenance organizations, surgical centers, extended care facilities, and home health care services.

One other thing, Mr. Chairman, we ought to make clear: our amendment takes a little different approach from yours because it is an amendment to section 1525. I think we are going in the same direction, but we are still at work studying this, and we will have further discussions to make and would like permission to pass those on later on as to how we can achieve this goal, whether in the further expansion of our suggested change in the definition or through your approach to broaden the definition of capital expenditures.

Mr. ROGERS. We will be pleased to receive those suggestions.

Mr. McMAHON. On page 7 we mention the amendment we have suggested on the composition of planning body governing boards. We think it appropriate to identify the need for hospital administrators to have a place on the governing boards of planning agencies. We made reference also to the need to redefine the term "indirect provider" to facilitate selection of interested, informed and effective consumer representatives.

In a survey we have undertaken, preliminary indicate half of the planning agencies don't have hospital management representa-



tives and, because of the importance of the hospital system, itself, in the area to the plans and in the modification of services over time, we think the planning process would be better served if they were there.

On page 9, Mr. Chairman, we have given attention to the problems of the confusion and duplication of construction standards and the multiplicity of agencies involved in their enforcement. These multiple codes produce added costs for institutions which must be passed on ultimately to producers and payers. We recommend a single set of codes and standards for the physical requirements of hospitals and other institutions and facilities. States and local governments would also be urged to adhere to these standards.

From pages 10 to 19 we have addressed some of the changes you set forth in H.R. 10460. I would like to address myself to only one of those. It begins on page 16 and it has to do specifically with the proposed new requirement that within four years States must have in effect a program under which services found to be inappropriate may not be provided in such States. We interpret this to mean there must be established a program of compulsory decertification and we oppose such a program. Compulsory decertification would cause serious community conflicts and raise issues of compliance with due process requirements, abrogation of contracts, and deprivation of private property without just compensation.

Closure, conversion, and merger of units, the steps that are effective means for dealing with excessive services, are likely to be successful if they are performed voluntarily, in conjunction with financial and other support from planning agencies, Government, and third-party payers.

We suggested—I am referring specifically to the language beginning at the top of page 17, that instead of compulsory decertification, consideration be given to substitute provisions to require the State to develop a program to facilitate the voluntary elimination of excessive services by helping to:

One: Satisfy the financial requirements related to the action;

Two: Provide orderly and timely access to alternate facilities and services for patients and physicians of the unit to be closed;

Three: Develop a plan for the best use of the unit to be closed;

Four: Secure other employment opportunities for employees of the unit; and

Five: Obtain the cooperation of the various parties affected by the change.

If steps such as these are taken, litigation, community opposition and political pressures to prevent the closure of services can be minimized. Therefore, we recommend this approach to obtaining cooperation in the elimination of excess capacity and duplication of facilities and services.

Thank you very much, Mr. Chairman, for the opportunity to present these thoughts.

We will at an appropriate time be pleased to answer any questions or elaborate on any of the points covered.

[Testimony resumes on p. 989.]

[Mr. McMahon's prepared statement and attachment follow:]


**AMERICAN HOSPITAL ASSOCIATION**

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION  
 BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
 OF THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE  
 ON H.R.10460  
 THE HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978

February 2, 1978

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me today are Leo J. Gehrig, M.D., Senior Vice President, and Paul W. Earle, Vice President, of the Association. Our Association represents some 6,500 member institutions, including most of the nation's hospitals, as well as extended and long-term care institutions, mental health facilities, hospital schools of nursing, and over 24,000 personal members. We appreciate this opportunity to present the views of the Association on Public Law 93-641, the National Health Planning and Resources Development Act of 1974, and your bill H.R.10460, the Health Planning and Resources Development Amendments of 1978, which would amend and extend this law.

Background

Our Association has supported the enactment and implementation of P.L.93-641, and we endorse this extension. We are committed to the overall goal of this legislation-- to improve access to quality health care services, while containing costs, through the development of effective planning processes at the local level. As a result of our continued interest and involvement in the implementation of P.L.93-641, we have identified, and strongly recommend to this committee, some specific amendments



to this Act. These amendments deal with areas of concern to the hospital field which we believe warrant modifications that will improve the basic statute.

We believe that health planning must be based on health needs identified by Health Systems Agencies (HSAs) and others through a number of planning techniques. The methodology of planning must take into account a variety of factors which apply to the planning area, including the incidence and prevalence of disease, the socio-demographic characteristics of the population, the present status of the health care delivery system, and the attitudes of the community regarding the delivery of health care services.

The key objective of such planning is the development of a health care delivery system that meets the health needs of all the people in the area and is adaptive to changes in these needs. Because of its important role in the provision of health care services, the hospital has a special responsibility to plan effectively; indeed, it is a major focus of attention in the planning effort. Therefore, it is particularly important that hospitals be represented and participate in the planning process at all levels--local, state, and national.

We strongly support and encourage the development by HEW of sound health planning tools, guidelines, standards, and methodologies to assist the planning agencies at the local and state levels, without imposing rigid formulas from the top. The health planning process can work most effectively through a "bottom-up" approach. Such an approach must provide for a clear-cut distinction between health planning at the local level; health planning and regulation on the state level; and the role of the federal government in providing guidelines and support at the national level.

An important problem in the implementation of this Act has been the difficulty encountered by planning agencies in establishing viable and up-to-date health care plans for the areas served. Only 9 of the 206 HSAs have been fully designated,

indicating that they have approved Health System Plans (HSPs). In addition, while more than 70 percent of all the states have certificate-of-need (CON) laws, only one state has had its CON program approved under the P.L.93-641 implementing regulations. The exigencies of developing regulations, recruiting staff, and securing adequate funds have combined to impede the development of the health plans that are essential to such state-level regulatory processes as CON for the control of capital expenditures.

Health planning, CON, and quality assurance programs are some of the cost containment efforts which have been, and are, underway. The voluntary effort to control costs currently being undertaken by this Association, together with the American Medical Association and the Federation of American Hospitals, will complement these statutory programs. This voluntary effort is headed by a National Steering Committee on Voluntary Cost Containment, which includes representatives of hospitals, physicians, insurers, consumers, industry, and management. State-level committees, under the leadership of state hospital associations and state medical societies, with similar representation, are being established to adapt the national objectives of this steering committee to local situations. The voluntary program is seeking to address inflation in health care costs which have been impacted by such factors as rises in the costs of goods and services hospitals must purchase, improvements in the services they offer, and increases in the intensity and demand for the care they provide. We would be pleased to supply for the record additional materials concerning this program, if the committee desires.

#### Summary of AHA Recommended Amendments to P.L.93-641

As we have stated previously, the issue of health planning has been a top priority of the Association. The following recommended amendments to the law address certain problems that we have observed in the implementation of this program. We are pleased

to note that some of these problems are also addressed in the changes provided for in your bill, H.R.10460. Mr. Chairman, we urge you and the committee to favorably consider our recommendations in revising the law. Detailed rationales and legislative language for each of our suggested amendments are appended.

#### National Guidelines for Health Planning

As a first step in ensuring a sound and effective planning process, at the local and state levels, we strongly believe that the National Guidelines for Health Planning should serve as a flexible guide to the development of local health plans and objectives. Mandatory federal guidelines imposed uniformly by each HSA and in each state, with modifications only through a cumbersome exceptions process (as previously proposed by HEW in regulations), would prevent the development of viable health service plans adapted to local needs. They would also make the federal government the preeminent planner and others mere agents carrying out the will of those at the top.

We believe that whenever standards, numbers, and formulas are developed in HEW guidelines, they should be considered in the light of and adapted to local situations. To clarify the relationships between local and national authorities, as intended in the original law, the Association proposes an amendment to Section 1513(b) which will make it clear that the National Guidelines be taken into consideration by HSAs, in the formulation of health plans, rather than be imposed as inflexible, mandatory rules, to be rigidly followed at the local level.

#### Functions and Procedures of Planning Agencies

We firmly believe that the scope of CON should be broadened and that the functions and procedures of planning agencies should be more adequately defined, to increase the effectiveness and equity of the health planning program. Following are several amendments which are designed to achieve these goals.

- A. The first of these amendments would expand the scope of the requirement for state CON laws to encompass health capital expenditures without regard to ownership or location. We believe that the private offices of health practitioners should be subject to CON review to the extent that those offices are proposing to obtain highly specialized equipment or develop facilities that are typically provided in an institutional setting. It is our belief that the scope of the CON process should not be limited to a portion of the health system. For example, the requirement for CON must prevent not only the undue proliferation of hospital-based CAT scanners, but also the proliferation of such scanners in other settings. In addition to the application of CON to the physician's office as we have described, CON coverage should also apply to such activities as health maintenance organizations, ambulatory surgical centers, extended-care facilities, and home health services. Health facilities and services can now be established in a variety of settings, without following local and state health plans and without obtaining CON approval while in other settings these same facilities and services are subject to rigorous controls.
- B. We also are recommending a group of related amendments that are designed to clarify the advisory roles of HSAs and Statewide Health Coordinating Councils (SHCCs) with regard to review of applications for various types of federal funds. Current law suggests that the federal government has delegated to HSAs, and, in some instances, to SHCCs, the decision-making authority over applications for federal health grants to local entities or to states. We do not believe that this is, or should be, the practice.

The distinction which we propose between advisory and decision-making roles would keep local planning agencies in the business of planning and out of the realm of making grant awards. The final decision regarding federal project grants rests with the responsible federal agency, taking into account the recommendations of local planning units.

In a related issue, we believe that the provisions of P.L.93-641 which would provide area health services development funds to HSAs should be changed. This authority dilutes the focus of HSA planning activity by extending the functions of the agency to grant making and grant managing. While we agree that these development funds should be available to meet certain identified local needs, we believe that grant making and grant managing in this program should be the responsibility of the state agency, rather than of the HSA. Statewide health services development funds should be earmarked for projects which have been identified and recommended by HSAs.

- C. Additional amendments we propose would consolidate all of the P.L.93-641 requirements for review procedures into Section 1532, where most of them now appear. These amendments would (1) require that proposed projects shall be deemed to be approved unless they are rejected by written opinion within the 90-day statutory review period; (2) provide for a public forum to be held by the HSA, at the local level, at which all interested persons may appear and present statements or evidence on the application being considered or the review being conducted; and (3) permit a formal hearing to be requested by either the HSA or the applicant, prior to the decision of the state agency, on a CON application or appropriateness review.
- D. Our Association believes that the planning process would be strengthened if HSAs were permitted initially to phase in their functions in an orderly manner, according to their capabilities and resources. We are proposing an amendment to Section 1513(b) to accomplish this purpose. We believe that our amendment would improve the credibility and effectiveness of HSAs by requiring them to perform functions within--rather than beyond--their capabilities and resources.



Composition of Planning Body Governing Boards

The underlying philosophy of P.L.93-641 is that health care planning is to be developed through an effective coalition, at the local level, of consumer and provider representatives. Confusion and ambiguity in the language of the statute regarding representational requirements on HSA governing boards have, in some instances, impeded the achievement of this important goal of the Act. Accordingly, we have developed amendments to Sections 1503(b), 1512(b), and 1524(b) that would assure direct representation of hospital administrators on the governing boards of planning agencies, and that would redefine the term "indirect provider" to facilitate selection of interested, informed, and effective consumer representatives.

- A. Current law does not require that hospitals be represented by persons directly involved in hospital administration. Therefore, institutions may be represented by individuals who are not in the best position to reflect the views of hospital management. We propose amendments to ensure that representatives of hospital administration be included at all levels of the planning process, and be eligible for membership on an HSA board if either their residence or place of principal employment is within the health service area.
- B. Although the potential for economic conflicts of interest is a valid concern, the definition of "indirect provider" in Section 1531 is overly broad. We believe that the definition misclassifies as providers persons who have only tangential, incidental, or indirect ties to the health system. The definition also includes others, such as insurers, whose roles and responsibilities are those of purchasers. Such persons should be classified as consumer representatives.

Accordingly, the Association recommends amendments that would revise the definition of "indirect provider" to exclude (1) members of the immediate family of an indirect provider, (2) any individual who receives less than one quarter

of his or her gross income from a health care interest, a direct provider, or certain other health activities, and (3) insurers who do not provide health services to the public, either directly or through affiliates or subsidiaries.

#### Appropriateness Review

We suggest that the appropriateness review sections in P.L.93-641 are unnecessary and recommend their deletion from the law. A definition of this function has not been developed, and standards and guidelines have not been proposed to assist HSAs and state agencies with implementation--reflections of the difficulties this requirement poses.

A major problem is created by the fact that the law now requires HSAs and state agencies to review, on a periodic basis, each individual service and facility within the area or the state to determine its appropriateness. The magnitude of this burden can be appreciated when one considers that there are over 7,000 hospitals, many of which provide a broad range of services; more than 22,000 nursing homes; and many other institutional providers--all of which require appropriateness review. We believe that such a requirement adds an impossible burden to planning agencies, which have more urgent tasks to accomplish.

We believe that the overall assessment of the appropriateness of facilities and services is a part of the preparation of an HSP. On the other hand, we do not believe that an individual review for appropriateness of the myriad of services offered in an area is an effective use of planning resources. Therefore, we recommend the deletion of appropriateness review from the functions of HSAs, as detailed in Section 1513(g), and State Health Planning and Development Agencies (SHPDAs), as stated in Sections 1523(a)(b) and 1523(b)(3).

Federal Hospital Construction Standards

Health care facilities are frequently subject to the construction standards of a multiplicity of agencies. Federal agencies, such as HEW, the Department of Labor, and the Department of Housing and Urban Development, often require compliance with construction standards as a condition for participation in their programs or for financial assistance. State and local agencies also impose standards through various certification of licensure laws and building, fire, and sanitation codes.

Further complicating the situation is the fact that new codes are constantly under development and old ones are subject to frequent revisions. Different authorities often enforce different revisions. Multiple codes produce added costs for institutions, which ultimately must be passed on to their patients and to third-party payers.

The Association believes that the federal government should take the lead in resolving this situation by developing a single set of codes and standards for the physical requirements of hospitals and other institutional health facilities which would apply to all federal programs and to which state and local governments would be encouraged to adhere.

In regard to state and local authorities, there may be, in some instances, a demonstrated need for different emphases in different parts of the country because of geographical or environmental distinctions. These distinctions can generally be accommodated by permitting state and local authorities to impose additional, but not conflicting, requirements to account for hazards from earthquakes, hurricanes, floods, blizzards, and the like.

#### Provision of 'Free Care'

Under the original Hill-Burton Act (Title VI of the Public Health Service Act) implementing regulations, each applicant for a hospital construction grant was required to assure that a reasonable volume of hospital services, subject to financial feasibility, would be made available by the hospital to persons unable to pay--a provision still in effect. The statute also included a provision that, if any hospital receiving assistance under the program would cease operation or be converted from use as a nonprofit facility within 20 years from the completion of construction, the United States would be entitled to recover a portion of the assistance provided. No repayment was required beyond the 20-year period.

Some 25 years after the original law was enacted, additional regulations were promulgated to quantify the volume of free services which those receiving Hill-Burton assistance would be required to provide. Under these regulations, as amended and now in effect, hospitals in receipt of Hill-Burton assistance are required to account, during a 20-year period, for the free care they provide. The total cost of free care that can be required within the 20-year period may be twice the amount of the original Hill-Burton assistance, or even more.

Recognizing that hospitals not only have provided, but also will continue to provide, free care to persons unable to pay, we oppose imposition of a burdensome reporting and verification system in perpetuity, as included in the proposed new Subparagraph(J) of Paragraph 1621(b)(1) of your bill. Instead, we recommend that such required reporting continue to be limited to the 20-year recovery period, and ask that the committee adopt our amendment which provides for this limitation.

#### Grants and Contributions to HSAs

Health planning agencies must be assured adequate funds during their critical stage of development. Therefore, we propose amendments to Sections 1512(b) and 1516(b) which would permit a broader base of private and public contributions to HSAs.

### Uniform Cost Accounting and Reporting

The AHA supports uniform reporting of costs, rates, and services, but does not favor extension of that principle to the requirement of uniform accounting for all health care institutions. We recommend that the portion of Section 1533(d) which requires the development of uniform cost-accounting and -reporting systems be amended to make it consistent with the provisions for uniform reporting and reconciliation systems that were enacted last year in Section 19(a) of the Medicare and Medicaid Anti-Fraud and -Abuse Amendments, P.L.95-142. In addition, we recommend amendment of Section 1502(9) to be consistent with these recommended changes in Section 1533(d).

### Legal Structure of HSAs

P.L.93-641 currently permits not-for-profit corporations, public regional planning bodies, or units of local government to be designated as HSAs. We believe there would be a conflict of interest if an agency of local government, which was also a major purchaser or provider of health services, were designated as an HSA. We propose an amendment to clarify that governmental agencies that are substantial purchasers or substantial providers of health care services should not be designated as HSAs. This amendment is proposed to prevent the possibility that decisions about health planning and resource allocation will be made by agencies with the responsibility of purchasing or providing health care services.

### Coordination of Planning

The Association supports amendments which would encourage coordination between the internal planning efforts of health care institutions and planning by HSAs. Experience has demonstrated that effective health planning requires a combination of individual efforts and extensive cooperation between public planning agencies and institutions within the planning area. The health planning statute should



recognize that planning agencies and health care institutions each have responsibility in the total planning effort.

The HSA should help determine what services and facilities are necessary to achieve the most effective and efficient levels and scope of health care for the health service area, within local resource limitations. On the other hand, the HSA's responsibility should stop short of determining how such services should be administered and how such facilities should be managed. These functions are the responsibility of hospital management. Hospital administrators, trustees, and medical staffs are best able to evaluate the needs and capabilities of their institutions and to assess actions for improving them. Regulations enforced by the HSA should provide freedom for the exercise of management prerogatives to attain planning objectives. To this end, the Association recommends an amendment to Section 1513(d) and adds a new Subsection (i) to Section 1513.

#### AHA Views on H.R.10460

Mr. Chairman, to assist the committee in its deliberations, we would like to share with you our reaction to some of the provisions of H.R.10460, the Health Planning and Resources Development Amendments of 1978. We wish to indicate our support for many of the changes in P.L.93-641 which you have incorporated in the bill and to recommend either modification or deletion of other provisions in the legislation.

#### Section 208--Local Financial Support of HSAs

AHA supports Section 208, which allows HSAs to accept financial support from insurers and permits such support to be counted for purposes of federal matching funds. The success of health planning at the HSA level depends not only on the quality of staff but also on the resources available. We feel that health insurers can provide

HSAs with important financial support without introducing significant potential for conflict of interest in the planning process. In this regard, we support at least this proposed expansion of non-federal funding sources, and we have detailed our recommendation for further expansion in an attached amendment.

#### Section 209--Membership Requirements

In general, we favor the changes made in Section 209; in addition, we propose that Paragraph (2) of Section 209(d) be modified so that the definition of "indirect provider" excludes the spouse as well as other members of the immediate family of an "indirect provider."

We also note that one of our proposed amendments would change the requirements for composition of HSA governing boards to insure that the provider members include a direct representative of hospital administration. We are pleased that you have provided in Paragraph (2) of Section 209(d) that an individual can qualify for HSA board membership on the basis of either place of residence or place of employment.

#### Section 213--Support and Reimbursement for Members of Governing Bodies; Section 215--Staff Expertise

AHA supports Sections 213 and 215, which require that HSAs have a program of training and education for board and executive committee members, and that HSA staff expertise include finance, economics, and public health issues. Rational planning decisions can be made only by informed, knowledgeable individuals who have the benefit of adequate staff work. The addition of these requirements will certainly strengthen the planning process.

We suggest, however, that Section 215 be modified to include a requirement that HSA staff expertise encompass hospital administration, inasmuch as a full understanding of the complexities of operating and financing a hospital is essential for the proper analysis of institutional health care.

Section 216--Health Plan Requirements

We note that Subsection 216(a) of the bill would require that a SHCC establish a "uniform format" for HSPs, and that Paragraph (2) of Section 216(c) would require HSPs to be responsive to statewide health needs that are identified by the SHPDA.

In our view, the term "uniform format" needs to be more precisely defined. If the subcommittee's intention is that the SHCC shall prescribe the organization and presentation of HSPs to achieve a uniformity to facilitate review, then we do not object. However, the term as currently drafted could result in a SHCC's attempting to impose a particular methodology on HSAs for the actual development of the HSP. We would oppose this authority for SHCCs, and we suggest that this provision be redrafted to clarify its intent.

With regard to Paragraph (2) of Section 216(c), we suggest that such an amendment would confuse the existing statutory relationship between HSAs, SHPDAs, and SHCCs, in that present law provides that SHCCs review and require revision of HSPs with a view toward coordinating local health goals and statewide needs. The addition of a provision which permits a direct reconciliation between the SHPDA and the HSA would confuse the process and duplicate the function of the SHCC. We recommend either deletion of this provision, or the substitution of "SHCC" for "SHPDA," to retain current procedures.

Section 218--CON Programs

In our view, an important amendment in H.R.10460 is contained in Paragraphs (1) and (3) of Section 218(b), which expand federal requirements for state CON programs, to mandate coverage of major medical equipment, certain defined capital expenditures by health care facilities, and home health services. Our Association strongly supports these provisions, because we believe that uniform application of state CON programs to services and facilities is essential to an effective planning process.

Specifically, we feel that CON must cover major medical equipment regardless of ownership or setting, as well as health services that would otherwise be covered by the review process if proposed by institutional providers. This, of course, would not extend coverage to expenditures involving private practitioners in the development or maintenance of a usual practice.

Failure to expand CON coverage could only encourage the proliferation of major medical equipment, facilities, and services in a manner wholly inconsistent with the purpose of the Act. Progress toward the goals established in local and state health plans could be seriously undermined.

Further, we support the proposed new Paragraph (5) of Section 1527(a), which would require that CON programs have an identified appeals mechanism for applicants to seek review of adverse CON decisions, with such mechanism established consistent with individual state administrative practices and procedures.

We also suggest redrafting of Paragraph (4) of Section 218(b), which would amend Section 1532(b)(2) of the Act to allow up to one year for action on CON applications after receipt by an HSA or a SHPDA. If the purpose of this amendment is to allow batch processing of applications, we must point out that the provision, as currently drafted, would make a one-year general delay on a final recommendation or decision permissible, even when batch processing is not an issue.

We oppose permitting such a delay between receipt and action on CON applications, because this would impede efforts to meet the needs of the health care delivery system, and would jeopardize the arrangements made by applicants for financing, purchase, and construction.

Finally, in this section, we suggest that the proposed Paragraph 6 of Section 1527(a), which requires that state agency decisions on CON applications be consistent with

the State Health Plan (SHP), is too restrictive, because one cannot reasonably expect that all justifiable needs will be anticipated in such a plan. We recommend that more flexibility be allowed, so that a state agency can grant CONs in cases in which there is clear need, though not specifically anticipated and included in the SHP.

#### Section 219--Appropriateness Review

Section 219 provides for two changes in the review of the appropriateness of services. The first of these changes would modify the requirement of present law that all institutional services be reviewed, to stipulate that reviews be made of only those institutional or home health services designated by the Secretary. As we testified earlier, we propose instead that the requirement for appropriateness reviews be deleted in its entirety.

The second proposed change would add a requirement that within four years a state must have in effect a program under which services found to be inappropriate "may not be provided" in such state. We interpret this to mean there must be established a program of compulsory decertification. We strongly oppose such a program.

Compulsory decertification will cause serious community conflicts and raise issues of compliance with due process requirements, abrogation of contracts, and deprivation of private property without just compensation.

Closure, conversion, and merger of units, the steps that are effective means for dealing with excessive services, are likely to be successful if they are performed voluntarily, in conjunction with financial and other support from planning agencies, government, and third-party payers.



Provision for financial and other incentives would be one element in establishing an environment in which voluntary elimination of excess services could be encouraged. While opposing Section 219, we suggest consideration of substitute provisions to require the state to develop a program to facilitate the voluntary elimination of excessive services by helping to:

- (1) satisfy the financial requirements related to the action;
- (2) provide orderly and timely access to alternate facilities and services for patients and physicians of the unit to be closed;
- (3) develop a plan for the best use of the unit to be closed;
- (4) secure other employment opportunities for employees of the unit; and
- (5) obtain the cooperation of the various parties affected by the change.

If steps such as these are taken, litigation, community opposition, and political pressures to prevent the closure of services can be minimized. Therefore, we recommend this approach to obtaining cooperation in the elimination of excess capacity and duplication of facilities and services.

#### Section 220--Review and Approval of Proposed Uses of Federal Funds

This provision amends in several respects the provisions of current law which relate to HSA and SHCC review and approval of federal grants and contracts. While we do not object to the intent of these amendments, we do recommend that this review function encompass "review and comment"--as we have proposed in our amendments--rather than "review and approval or disapproval."

#### Section 224--Authorizations

We note that there is a provision within Subsection 224 which increases the authorization for the area health services development fund, provided in Section 1640(d) of the Act. We support the level of the authorization, but urge the

adoption of our proposed amendment to transfer this activity from the HSA to the state agency. We believe that the authorization levels provided here would also be suitable for the state-level activity.

In this same area, we also would like to indicate support for the increases in the minimum grants to HSAs, for the change in the formula for calculating HSA planning grants proposed in Section 206 of the bill, and for the increases in overall authorizations for HSAs and state agencies contained in Section 224. An effective health planning process requires consistent and adequate financial support, particularly in its critical developmental phase.

#### Section 301--Health Resources Development

Section 301 of Title III of H.R.10460 would delete the present grant program for the modernization and construction of public and private not-for-profit health care facilities contained in Part B of Title XVI of the Act, and would extend the loan and loan guarantee program for such facilities under Part C. Further, the bill would amend Section 1625 to increase the authorization level for construction or modernization project grants to public hospitals to eliminate or prevent safety hazards or to avoid noncompliance with state or voluntary licensure or accreditation standards.

The AHA supports this needed program of assistance to public hospitals, but recommends that the authority be expanded to also include justified projects for private, not-for-profit facilities. Such a grant program would certainly be limited to assisting projects where both need and the financial condition of institutions make such support imperative. There are private not-for-profit facilities providing essential access to health care services in both urban and rural poverty areas which are incapable of mobilizing the necessary capital for the purposes identified in section 1625, and for whom loan qualification would not be feasible because of

their precarious financial condition. In these instances the availability of some government funds is crucial. Therefore, we recommend the inclusion of not-for-profit facilities in this targeted grant program.

The bill also would amend Section 1625 to authorize a new project grant program for the construction of outpatient medical facilities or the conversion of facilities to this use for medically underserved populations. We support this amendment and we again urge both government and private health insurers to improve their coverage for services provided in this setting.

We do oppose the proposed new Subparagraph (J) of Paragraph 1621(b)(1) in your bill. This subparagraph, in part, requires the accountability for charity care services to extend in perpetuity for any facility receiving assistance under this program. In the discussion of our amendments earlier, we included our reasons for this position and we urge the committee to delete this requirement.

#### Conclusion

Mr. Chairman, the American Hospital Association continues to support development of sound health planning through the successful implementation of the National Health Planning and Resources Development Act of 1974. You can be sure that we stand ready to assist you and the members of the committee in any way we can to modify the Act to assure such development.

We will be pleased to respond to any questions you or other members of the committee may have.

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT  
OF 1974

Amendment Proposals

February 1978

AMERICAN HOSPITAL ASSOCIATION

The following outlines the policy positions regarding the American Hospital Association amendments to the National Health Planning and Resources Development Act of 1974. These amendments reflect hospital concerns for the implementation of this Act and for achieving an orderly planning process for the health care industry.

Each amendment issue is described in the following way: First, there is the policy position of the American Hospital Association approved by the Board. Second, the rationale supporting each amendment is shown. Third, the new words to be included in the legislative language have been underlined and the words to be deleted have been crossed out.

1. Clarification of the Relationship between the National Goals and Standards and the Local Planning Activities  
Section 1513(b) (2)

- a. Policy Position. American Hospital Association supports amendments to P.L. 93-641 which will make it clear that planning activities are to be conducted primarily at the local level, with a minimum of interference from statewide and federal agencies.
- b. Rationale. In the preamble to proposed National Health Planning Guidelines, issued September 23, 1977, the Department of Health, Education and Welfare asserted its view that the national guidelines specified by Section 1501 of P.L. 93-641 were required to be included as minimum goals and standards in local health systems plans (HSPs) annual implementation plans (AIPs) and statewide health plans as well as in state medical facilities plans. This is an effort to impose "top down" planning instead of the "bottom up" planning which we believe was clearly intended by Congress in passing the statute. While supporting the issuance of national guidelines as targets for the nation as a whole to achieve, AHA opposes the Department's attempted extension of its statutory authority. Mandatory guidelines are a contradiction in terms which would hamstring health systems agencies in their planning efforts and would give preeminence to the role of federal planning. Such a result is contrary to the express requirement of the statute that health planning must be "responsive to the unique needs and resources of the [health service] area." (Section 1513(b) (2) (B).

To reinforce the balance between local and national authority which was struck by the original enactment, American Hospital Association proposes amendments to the law which will make it clear that although the national guidelines must be taken into consideration by health systems agencies, they are not to be considered as inflexible, mandatory parts of the local planning process.

- c. Legislative Language. American Hospital Association submits the following language as an amendment to the National Health Planning and Resources Development Act of 1974, to accomplish the foregoing objectives:

"Functions of Health Systems Agencies

SECTION 1513(b) (2)

\* \* \*

"(C) which take into account and-is-consistent-with the national guidelines for health planning policy issued by the Secretary under Section 1501 respecting supply, distribution, and organization of health resources and services."

"(5) The agency shall submit to the State Agency a detailed statement of the reasons for any inconsistency between its HSP or AIP and the national guidelines and priorities established under this Act."



## 2. Definition of Institutional Health Services Section 1531(5)

- a. Policy Position. The American Hospital Association supports an amendment to require a review of specialized equipment and facilities regardless of setting or ownership.
- b. Rationale. The purpose of this amendment is to clarify that the facilities and programs subject to review by Health Systems Agencies and approved by state certificate of need agencies should include all facilities and programs irrespective of ownership, exempting only the private offices of health practitioners to the extent that those offices do not include highly specialized equipment. We believe the principle regulatory tool assigned to the state government by P.L. 93-641 is certification of need (CON). It is the process whereby the state grants permission to health care providers to change their scope of services or to make significant capital improvements. No institution or service should be excluded from the certificate of need process because of its ownership, including a facility or service operated by a governmental or quasi-governmental agency or unit.

The pressures continue to arise wholly or partially to exempt this or that category of provider from the controls of certificate of need. The major response to these pleas for exemption is to ask where it would end. Is it really intended that certificate of need should cover only non-profit general inpatient care facilities? Is it realistic to expect certificate of need to hold down excessive health care costs if it can regulate only a portion of the development of the system's capacity? If a certificate of need program can, for example, try to prevent the proliferation of hospital based CAT scanners only to see a proliferation of CAT scanners by physician owners, has the law's intent really been served? If health maintenance organizations or ambulatory surgery centers or extended care facilities can be established without reference to state regulations and irrespective of how poorly planned they might be, what purpose is there in holding other kinds of facilities making similar proposals to more rigorous standards? If one goal of P.L. 93-641 is to contain health care costs by controlling the development of new or altered services and facilities, then we believe that no related institution or service should be excluded from the planning and review process regardless of ownership.

- c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy.

### DEFINITION OF INSTITUTIONAL HEALTH SERVICES Section 1531(5)

"(5) The term 'institutional health services' means the health services provided by or through health care facilities and health maintenance organizations irrespective of ownership (as such facilities and organizations are defined in regulations prescribed under section 1122 of the Social Security Act or in regulations prescribed under section 1523 of this Act), including, but not limited to hospitals; nursing homes; extended care institutions; ambulatory care facilities; clinical referral laboratories;

radiation therapy units; specialized radiographic units; mental health, alcoholism, and drug abuse facilities; rehabilitation centers; and other facilities for the provision of specialized health services and includes the entities through which such services are provided, but the term shall not include facilities established solely for the professional activities of physicians, dentists, or other health care practitioners practicing singly or in organized groups, except where such services are provided by or through highly technical or specialized facilities or equipment."

### 3. Review Functions of Health Systems Agencies Section 1513(e)(1) and (2)

- a. Policy Position. The American Hospital Association supports an amendment to ensure that Health Systems Agencies review and make recommendations and, as such, are advisory rather than decision-making bodies.
- b. Rationale. The purpose of this amendment is to clarify that the responsibilities of the Health Systems Agency (HSA) should be advisory only, and that its function should be to review and make recommendations to the HEW Secretary or to the State Agency, as the case may be.

We believe that the Health Systems Agency should neither commit funds nor deny them. We believe that this change should be made because ambiguous wording in the current law suggests that the federal government has delegated to Health Systems Agencies final decision-making authority over federal health grants in the local area. Of course, a local Health Systems Agency's approval or disapproval of an application to a federal agency for a grant does not constitute final federal action. The Secretary of HEW can choose to commit federal funds in a manner inconsistent with a Health Systems Agency's recommendations. It is hoped, however, that the recommendations by the Health Systems Agency would be taken seriously by the Secretary and the State Agency. Further, this amendment would require that when the Secretary or State Agency makes a decision regarding a grant or contract that is contrary to the recommendation of the Health Systems Agency, a written explanation must be provided to the applicant and to the Health Systems Agency.

Planning agencies have been given the responsibility to review proposals to determine their consistency with established areawide health plans, not, we believe, to approve or disapprove of projects. As we view it, this difference is critical to the planning concept. It keeps the planning agencies in the business of planning and out of the realm of regulation. Regulation is generally aimed at controlling or limiting, while proper planning activities may, in many cases, call for identification of need for new services.

Unfortunately, because of the subtlety of language and the ambiguity of the interpretation, section 1513(c)(1) and (2) is already beginning to compound some of the problems of planning. Many planning agencies faced with start-up difficulties and inadequate funding have not yet established viable and on-going plans to meet the health needs of the community they serve, or at best, have only developed simplistic guidelines or formulas. The legislation as it now reads will only add complexity to an unrefined or underdeveloped process. In addition, although its language separates planning from regulation, many planning agencies, and some federal agencies, have already misinterpreted this section by translating the phrase "review and comment" to mean review and approval or disapproval, and to that extent have undermined the concept of planning.

While we do recognize legitimate and desirable review and comment roles for health planning agencies, such review and comment functions can only be meaningfully carried out after adequate short and long range plans have been developed.

Planning, as the American Hospital Association interprets the process, should not be strengthened through providing planners with authority and responsibility

for regulation, but through strengthening planning capabilities and activities that so far, have been inadequately implemented or totally lacking.

Finally, the regulatory decision, once a judgment of consistency or inconsistency with established plans is made by the planning unit, should rest with a governmental unit, either at the state or federal level. This is the only way in which necessary checks and balances can be maintained, and the only way to bring about orderly change consistent with the available resources.

Therefore, we recommend that this section be amended so that the function is more accurately identified as review and recommendation by the Health Systems Agency.

- c. **Legislative Language.** The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy.

#### REVIEW FUNCTIONS OF HEALTH SYSTEMS AGENCIES

##### SECTIONS 1513(e)(1) and (2)

"(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and ~~approve-or-disapprove~~ make recommendations to the Secretary or, in the case of grants or contracts described in subparagraph (ii) of this paragraph, the appropriate State health planning and development agency on each proposed use within its health service area of Federal funds--

"(i) appropriated under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources; or

"(ii) made available by the State in which the health service area is located ~~(from an allotment to the State under an Act referred to in clause (i))~~ for grants or contracts for the development, expansion, or support of health resources.

"(B) A health systems agency shall not review and ~~approve-or-disapprove~~ make recommendations on the proposed use within its health service area of Federal funds appropriated for grants or contracts under title IV, VII, or VIII of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources intended for use in the health service area or the delivery of health services. In the case of a proposed use within the health service area of a health systems agency of Federal funds described in subparagraph (A) by an Indian tribe or inter-tribal Indian Organization for any program or project which will be located within or will specifically serve --

"(i) a federally-recognized Indian reservation,

"(ii) any land area in Oklahoma which is held in trust by the United States for Indians or which is restricted Indian-owned land area, or

"(iii) a Native village in Alaska (as defined in section 3(c) of the Alaska Native Claims Settlement Act),

a health systems agency shall only review and comment on such proposed use.



"(2) Notwithstanding any other provision of this Act or any other Act referred to in paragraph (1), the Secretary shall allow a health systems agency sixty days to make the review and recommendations required by such paragraph. If an agency ~~disapproves~~ recommends against a proposed use in its health service area of Federal funds described in paragraph (1)(A)(i), the Secretary may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency's ~~decision~~ recommendations. In making any such review of any agency's ~~decision~~ recommendations, the Secretary shall give the appropriate State health planning and development agency an opportunity to consider the ~~decision~~ recommendations of the health systems agency and to submit to the Secretary its comments on the ~~decision~~ recommendations. The Secretary, after taking into consideration such State agency's comments (if any), may make such Federal funds available for such use, notwithstanding the ~~disapproved~~ recommendations of the health systems agency. Each such decision by the Secretary to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision, including the comments, if any, of the State agency."



4. Review Functions of Statewide Health Coordinating Councils  
Section 1524(c)(6)
  - a. Policy Position. The American Hospital Association supports an amendment that Statewide Health Coordinating Councils are advisory Councils and would make recommendations to the Secretary.
  - b. Rationale. This amendment corresponds with the prior amendment regarding the review functions of Health Systems Agencies (see section 1513(e)(1)(2)). This would make the review functions of the Statewide Health Coordinating Council advisory only. The Councils could neither commit federal funds nor deny them. Like the Health Systems Agency, the Statewide Health Coordinating Council, or SHCC, is a planning agency, and its function in the review and approval process should be advisory only. Further, when the HEW Secretary or State Agency makes a decision regarding a grant or contract contrary to the recommendation of the Statewide Health Coordinating Council, we recommend that HEW provide a written explanation to the applicant as well as to the Health Systems Agency.
  - c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

REVIEW FUNCTIONS OF STATEWIDE HEALTH  
COORDINATING COUNCILS

SECTION 1524(c)(6)

"(c) A SHCC shall perform the following functions:

\* \* \*

"(6) Review annually and ~~approve or disapprove~~ make recommendations to the Secretary on any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Notwithstanding any other provision of this Act or any other Act referred to in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review and recommendations required by such sentence. If a SHCC ~~disapproves~~ recommends against such a State plan or application, the Secretary may not make Federal funds available under such State plan or application until he has made, upon request of the Governor of the State, which submitted such plan or application or another agency of such State, a review of the SHCC's ~~decision~~ recommendations. If after such review the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision."

5. Elimination of Grant Making Function of Health Systems Agencies Section 1513(c)(3)
- a. Policy Position. The American Hospital Association supports an amendment that would convert the Area Health Services Development Fund to the State Health Services Development Fund, to be administered by the designated State Agency.
- b. Rationale. The purpose of this amendment is to eliminate the grant-making function from the functions mandated for a Health Systems Agency (HSA). Instead, Health Systems Agencies would solicit proposals from individuals, public and non-profit private entities. These proposals would assist the Health Systems Agencies in planning and developing projects and programs which they deem necessary for the achievement of the goals described in their health systems plans and annual implementation plans. The proposals would then be submitted to the State Health Planning and Development Agencies, which would be responsible for selecting and funding the proposals.

We disagree with the assignment to Health System Agencies of direct developmental assistance functions. However, we are in agreement that a developmental assistance function is necessary and should be supported by federal funds. We believe that this activity should be the responsibility of the State Agency. Health Systems Agencies' planning functions should be limited to reviewing and making recommendations on developmental proposals in light of the established plans. To provide Health Systems Agency planners with resources to implement their own plans, would detract from the principal function of the planning agency. Health Systems Agencies are more appropriately advisory to another agency. When development funds are at the local level, a conflict of interest may well be unavoidable. For instance, a problem may arise when Area Health Services Development Fund support is sought for activities which may result in projects or programs which will require an eventual formal review by the Health Systems Agency that underwrote its planning. The Health Systems Agency would then be presented with the inherent conflict of having to review objectively a proposal which was planned with Area Health Services Development Funds made available by the Health Systems Agency, but the Health Systems Agency would also have to face the possibility that, when presented with the details of the proposal listed in the annual implementation plan, it would refuse its endorsement and thereby repudiate its own plan. It might also be noted that the danger of litigation would be real if entities in the community make a major investment of their time and material resources in the development of a project which is listed in the annual implementation plan and/or stimulated by the award of Area Health Services Development Fund monies to underwrite its planning but then failed to receive Health Systems Agency endorsement and a certificate of need. These dangers, it would seem, would be eliminated if health services development funds were specifically limited to planning for projects already endorsed by the Health Systems Agency review procedures and to planning activities of the kind that would not result in proposals requiring Health Systems Agency review.

- c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy.

ELIMINATION OF THE GRANT MAKING FUNCTION OF  
HEALTH SYSTEMS AGENCIES  
SECTION 1513(c)(3)

"(c) A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

\* \* \*

"(3) The agency shall, in accordance with the priorities established in the AIP, ~~make grants to public and nonprofit private entities and enter into contracts with~~ solicit proposals from individuals and public and nonprofit private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. The proposals shall be submitted with the agency's review and recommendations to the State health planning and developing agency. ~~Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 1640. No grants or contract under this subsection may be used--(A) to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary), or (B) for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one-year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program.~~"

6. Funding of Proposals by State Agencies  
Section 1523(a)(1)

- a. Policy Position. The American Hospital Association supports an amendment that would give the grant-making function to State Health Planning and Development Agencies.
- b. Rationale. This amendment would authorize State Agencies to provide financial support for implementation of the plans of Health Systems Agencies (HSAs). The financial support would be derived from the State Health Services Development Fund established pursuant to section 1640. As stated earlier, we disagree with the provision of the law mandating Health Systems Agencies to carry on the function of direct developmental assistance. We are in agreement that a developmental assistance function is necessary and should be supported by federal funds. However, the developmental program activity should be the responsibility of a state level agency which would be able to determine state-wide priorities and more effectively allocate federal funds. This would also help avoid a conflict for Health Systems Agencies of having to review objectively a proposal which was planned with area health services development funds made available directly by the Health Systems Agency. This problem would be eliminated if development funds were specifically limited to planning for projects already endorsed by the Health Systems Agency's review and procedures or to planning activities of the kind that would not result in proposals requiring Health Systems Agency review.
- c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

FUNDING OF PROPOSALS BY STATE AGENCIES  
SECTION 1523(a)(1)

"SEC. 1523. (a) Each State Agency of a State designated under section 1521(b)(3) shall, except as authorized under subsection (b), perform within the State the following functions:

"(1) Conduct the health planning activities of the State and support the implementation of those parts of the State health plan (under section 1524(c)(2)) and the plans of the health systems agencies within the State which relate to the government of the State and to the health care delivery system in the State, through the agencies of State government and through the State Health Services Development Fund established pursuant to section 1640, which have received review and recommendation by the HSA or are not subject to such review and recommendation."



7. State Health Services Development Funds  
Section 1640

- a. Policy Position. The American Hospital Association supports an amendment to establish a State Health Services Development Fund.
- b. Rationale. The purpose of this amendment is to convert the Area Health Service Development Funds into a single State Health Services Development Fund. These funds could be used by State Agencies to make grants and enter into contracts on behalf of the Health Systems Agencies in accordance with section 1523(a)(1). We would envision the state government acting as a trustee for the development funds and that grants would be made only upon the recommendation of the agency which has the agreement with the Secretary for that state function. There are a number of safeguards which may be included, such as a provision that the Health Systems Agency and the State Agency must agree before projects become funded. The role of the Statewide Health Coordinating Council might well be as one of a sounding board.
- c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

STATE HEALTH SERVICES DEVELOPMENT FUNDS  
SECTION 1640

"Part F -- Area State Health Services  
Development Funds

"Development Grants for Area State  
Health Services Development Funds

"SEC. 1640. (a) The Secretary shall make in each fiscal year a grant to each State health planning and development agency in each State, in which there is at least one health systems agency --

"(1) with which there is in effect a designation agreement under section 1515(c),

"(2) which has in effect an HSP and AIP reviewed by the Statewide Health Coordinating Council, and

"(3) which, as determined under the review made under section 1535 (c), is organized and operated in a manner prescribed by section 1512(b) and is performing its functions under section 1513 in a manner satisfactory to the Secretary,

to enable the State agency to establish and maintain an Area State Health Services Development Fund from which it may make grants and enter into contracts in accordance with section ~~1513(e)(3)~~ 1523(a)(1).

"(b)(1) Except as provided in paragraph (2), the amount of any grant under subsection (a) shall be determined by the Secretary after taking into consideration the population ~~of the health service area for which the health systems agency is designated~~ within the State, the average family income of the area State, and the supply of health services in the area State.

"(2) The amount of any grant under subsection (a) to a health systems State agency for any fiscal year may not exceed the product of \$1 and the population of the health service areas ~~for which such agency is designated~~ State. "



8. Schedules for Project Reviews.  
Section 1532(b)

- a. Policy Position. The American Hospital Association supports an amendment to P.L. 93-641, which would require that project reviews under state certificate of need laws and section 1122 of the Social Security Act be completed within 90 days of submission of complete information concerning a project, with the project being deemed to be approved if it is not rejected within that time period.
- b. Rationale. In prescribing procedures to be followed in conducting project reviews under section 1122, the Secretary of HEW provided that projects would be deemed to be approved unless they were specifically disapproved by the designated planning agency within 90 days from the date that complete information concerning such projects was submitted. That regulation has worked well in the five years that section 1122 has been in place. Its effect has been to force the reviewing agencies to rule upon applications with dispatch and to provide written explanation for every negative decision.

In promulgating regulations setting forth minimum standards for state certificate of need laws, the Secretary reversed that presumption. The original draft regulations, published for public comment on March 19, 1976, did not specify the effect of inaction by the state agency, although section 1122 regulations which were republished at that time continued the "approval by silence" rule for those reviews.

However, without explanation and without reference to any comments received from the public an inconsistent rule was adopted with respect to the requirements for state laws. Section 123.407(a)(15) of the regulations mandates that state laws provide that "if the state agency does not make a decision regarding a proposed new institutional health service within a period of time specified for state agency review, the proposal shall be deemed to have been found not to be needed." This complete turnaround mandates a startling inconsistency between section 1122 procedures and those required for state certificate of need laws. Thus, a project might be deemed to be approved for federal reimbursement but be deemed to be disapproved under state law. Grave uncertainty would result from this situation.

More important than mere inconsistency, however, is the fact that the Secretary's new position permits, for the first time, imposition of a "pocket veto" on a project, without any need on the part of the state agency to provide a written explanation of its action. Since project sponsors have been granted the right of appeal and a fair hearing, they must decide whether or not to appeal without knowledge of the reasons that their applications have been denied. It is doubtful that a "fair hearing" can in fact be provided unless the reason for the action being appealed has been made known. Due process questions arise from such a "pocket veto".

Serious discredit could be brought to the planning process by continued use of the "pocket veto". It encourages unnecessary delay and secrecy and can substantially handicap both public and provider understanding of the reasons behind agency actions. In the present inflationary

environment, every month of delay in reaching decisions on proposed projects adds perceptibly to the cost of such projects. Federal policy should encourage prompt action and openness in the planning process.

- c. Legislative Language. The following legislative changes are proposed:

Procedures and Criteria for Reviews of  
Proposed Health Systems

"Sec. 1532

\* \* \*

"(b) Each health systems agency and State Agency shall include in the procedures required by subsection (a) at least the following:

"(1) Written notification to affected persons of the beginning of a review, which shall be given within five days of the date that all information described in paragraph (3) is submitted."

"(2) Schedules for reviews conducted in discharge of the functions described in paragraph (4) of subsection 1523 (a) which provide that no such review shall, to the extent practicable, except with the consent of the person subject to such review, take longer than ninety days from the date that the notification described in paragraph (1) is made. Failure of the State Agency to act on a proposal within such period shall be deemed to constitute approval of such proposal."

9. Hearings for Project Reviews at State and Local Levels  
Sections 1522(b), 1532(a) and 1532(b)

- a. **Policy Position.** American Hospital Association supports an amendment to the National Health Planning and Resources Development Act to require a public forum for all interested parties who desire to participate in project reviews at the local level and to permit either the HSA or the applicant to request a formal hearing prior to any decision being made at the state level in a certificate of need or Section 1122 project review or in a review of the appropriateness of institutional health services.
- b. **Rationale.** Although Section 1532(8) of the statute requires public hearings during the course of project reviews and appropriateness reviews, it is vague as to the stage of the proceedings at which such hearings shall take place. There is also a requirement for public hearings "for good cause shown" after HSA and State Agency decisions, but, again, the timing and location are not specified. We suggest that it would be appropriate to provide for one public hearing at the local level, at which all interested persons would have the opportunity to make statements or present evidence with respect to the application or other review. To provide the maximum opportunity for such participation, such a hearing should be well publicized, informal in nature and conducted in the local community. A summary, although not a verbatim transcript, should be made, which should become part of the record of the total review process, and form part of the basis for the recommendations of the HSA and the decisions of the State Agency.

A second public hearing would generally tend to be merely repetitious of the statements and comments made at the first. However, there ought to be an opportunity for either the applicant or the HSA to request a formal hearing conducted by the State Agency prior to its decision. The interests of fairness and equity then would require that the decision be appealable by either party to the formal hearing, to a state agency other than the State Health Planning and Development Agency and thence to the courts to the extent provided by state law. At present, such an appeal is provided to the health systems agency only if the SHPDA decision is inconsistent with HSA recommendations. The existence of a right of appeal on the part of a project sponsor depends upon state law and on whether review is being conducted under Section 1122 of the Social Security Act or under a state certificate of need program. There are no provisions for institutions to appeal adverse findings made in the course of appropriateness reviews, even though these can have serious detrimental effects.

The amendments proposed will: (i) consolidate all the P.L.93-641 requirements for review procedures into Section 1532, where the bulk of them now appear; (ii) require that the procedures for the different kinds of reviews be harmonized, to the extent permitted by the statutes under which the reviews are being conducted, making it clear that the regulatory process must not contravene statutory requirements; (iii) provide for a public forum to be conducted by the health systems agency, at which all interested persons may appear and present statements or evidence concerning the review being conducted; (iv) require a formal hearing prior to the decision of the State Agency, at the request of either the health systems agency or the sponsor of a project or the institution whose services are being reviewed for their appropriateness.

- c. Legislative Language. The following specific legislative language is proposed to accomplish the changes in the National Health Planning and Resources Development Act set forth above.

#### HEARINGS AND PROCEDURES

#### SECTIONS 1522(b), 1532(a) and 1532(b)

##### "State Administrative Program

\* \* \*

"Section 1522(b). The State Program of a State must --

\* \* \*

~~(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (9), (4), (5), or (6) of Section 1533(a) or under title XVI which is inconsistent with a recommendation made under Subsection (f), (g), or (h) of Section 1513 by a health systems agency with the State --~~

~~(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the State health planning and development agency) designated by the Governor, and~~

~~(B) the decision of the reviewing agency shall for purposes of this title and title XVI be considered the decision of the State health planning and development agency."~~

##### "Procedures and Criteria for Reviews of Proposed Health System Changes

"Section 1532. (a) In conducting reviews pursuant to Subsections (e), (f), and (g) of Section 1513 or in conducting any other reviews of proposed or existing health services, each health systems agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the agency in accordance with regulations of the Secretary; and in performing its review functions under Section 1523, a State Agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary. Procedures and criteria for reviews by health systems agencies and States Agencies must be in accordance with the State and Federal statutes pursuant to which such reviews are being conducted, but may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed.

(b) Each health systems agency and State Agency shall include in the procedures required by Subsection (a) at least the following:

\* \* \*

(8) Provision for public hearings in the course of agency review at which members of the public shall have opportunity to make statements and present relevant evidence; or provision for formal hearings to be conducted by the State Agency if requested by persons directly affected-by-the-review; the agency or the entity proposing the project or whose services are being reviewed; and provision for public hearings; for good-cause-shown; respecting agency and State Agency decisions; review of any decision by a State Agency in any matter subject to Subsection 1532(a) at the request of the health systems agency or of the entity offering or proposing to offer the services being reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the state health planning and development agency) designated by the Governor and, to the extent provided by State law, to the courts of the state. The decision of the reviewing agency or court shall, for purposes of this title, title XVI and Section 1122 of the Social Security Act be considered the decision of the state health planning and development agency;



10. Phase In of Functions of Health Systems Agencies  
Section 1513(b)

- a. Policy Position. The American Hospital Association supports an amendment to ensure that agencies do not perform functions which are beyond their capability.
- b. Rationale. The purpose of this amendment is to permit Health Systems Agency (HSA) functions to be phased in, in accordance with staff expertise and availability of funds. DHEW should evaluate each applicant's proposed work program according to the agency's level of expertise and financing. The magnitude of the tasks listed as functions of a Health Systems Agency is overwhelming. If Health Systems Agencies are permitted to phase-in their programs in an orderly manner, and are not mandated to attempt to perform functions that are beyond their capabilities and available resources, the credibility and effectiveness of the Health Systems Agencies will be greatly enhanced.

For example, we have recommended that the appropriateness review functions be deleted as it is felt that in the absence of adequate staffing or adequate funding a review of this magnitude would be prohibitive. In the event that our recommendation for deletion of the appropriateness review is not followed as one of the functions of an HSA and State Agency, we believe that this is a prime example of a function which should be phased in after all other functions are in place. The Health Systems Agencies have numerous tasks to perform. Should they try to accomplish all these tasks simultaneously the efforts in each of them will be less than satisfactory.

- c. Legislative Language. The following is proposed legislative language to amend The National Health Planning and Resources Development Act in accord with the above policy:

PHASE IN FUNCTIONS OF HEALTH SYSTEMS AGENCIES  
SECTION 1513(b)

"(b) In providing health planning and resources development for its health service area, a health systems agency shall perform, to the extent that its capabilities and approved work program permit, the following functions:

"(1) The agency shall assemble and analyze data concerning--

"(A) the status (and its determinants) of the health of the residents of its health service area.

"(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

"(C) the effect the area's health care delivery system has on the health of the residents of the area.

"(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities.

"(E) the patterns of utilization of the area's health resources, and,

"(F) the environmental and occupational exposure factors affecting immediate and long-term health conditions."

11. Composition of National Council on Health Planning and Development  
Section 1503(b)(1)

- a. Policy Position. The American Hospital Association supports an amendment to ensure hospital representation at the national level.
- b. Rationale. As the legislation is now written, there is no provision to ensure adequate representation of hospital provider interests at the national level of the planning structure. Hospitals may therefore, be represented by someone who is not directly involved in health care delivery in hospitals and would not necessarily be in the best position to represent hospital needs. The underlying philosophy of the statute is that health care policy is to be developed through a coalition of representative consumer and provider interests. Because the nature of the representation categories is so broad and the various provider categories are so extensive, the possibility exists that the National Council could be composed of providers excluding a hospital representative unless there is specification that one of the five provider categories as listed in section 1512(b)(3)(C)(ii) should be a person who is a hospital representative. As this is a major category for the provision of health service, it is important to preclude this possibility.
- c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

COMPOSITION OF NATIONAL COUNCIL ON HEALTH  
PLANNING AND DEVELOPMENT

SECTION 1503(b)(1)

"(b)(1) The Council shall be composed of not less than fifteen nor more than twenty members. The Chief Medical Director of the Veteran's Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary for Health of the Department of Health, Education, and Welfare shall be nonvoting ex officio members of the Council. The remaining members shall be appointed by the Secretary and shall be persons who, as a result of their training, experience, or attainments, are exceptionally well qualified to assist in carrying out the functions of the Council. Of the voting members, not less than one shall represent each of the five classifications of providers enumerated in section 1512(b)(3)(C)(ii), not less than five shall be persons who are not providers of health services, not more than three shall be officers or employees of the Federal Government, not less than three shall be members of governing bodies of health systems agencies designated under part B, and not less than three shall be members of Statewide Health Coordinating Councils under section 1524 and not less than one shall be representative of hospital administration. The two major political parties shall have equal representation among the voting members on the Council."

12. Composition of Statewide Health Coordinating Councils  
Section 1524(b)(1)(C)

- a. Policy Position. The American Hospital Association supports an amendment to ensure hospital representation at the state level and to increase the proportion of direct providers at the state level.
- b. Rationale. As the legislation is now written, there is no provision to ensure adequate representation of hospital provider interests at the state level of the planning structure. Hospitals may therefore, be represented by someone who is not directly involved in health care delivery in hospitals and would not necessarily be in the best position to represent hospital needs. The underlying philosophy of the statute is that health care policy is to be developed through a coalition of representative consumer and provider interests. Because the nature of the representation categories is so broad and the various provider categories are so extensive, the possibility exists that the Statewide Health Coordinating Council could be composed of providers excluding a hospital representative unless there is specification that one of the five provider categories as listed in section 1512(b)(3)(C)(ii) should be a person who is a hospital representative. As this is a major category for the provision of health service, it is important to preclude this possibility.

In addition, this amendment is to increase the proportion of direct providers of health care on the Statewide Health Coordinating Council (SHCC) from one-third of the providers of health care to one-half. The importance of provider input to the decision making activities of the Statewide Health Coordinating Council cannot be too greatly emphasized. Because of the variance between the definition of those persons classified as indirect providers and those classified as direct providers, it is imperative to have the health care field adequately represented by those who do in fact directly provide health care services.

The amendment to increase direct providers on the Statewide Health Coordinating Council is consistent with our strong belief that health care and hospital membership at the national, state and local level should be appropriately represented. We believe a ratio of one-third direct provider and two-thirds indirect provider is an equitable balance.

- c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development in accord with the above policy:

COMPOSITION OF STATEWIDE HEALTH COORDINATING COUNCILS

SECTION 1524(b)(1)(C)

"(C) Not less than ~~one-third~~ one-half of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 1531(3)), and not less than one representative of each of the classifications of providers enumerated in section 1512(b)(3)(C)(ii) shall be represented on the SHCC of whom at least one shall be representative of hospital administration."

13. HSA Board Membership Requirements  
Section 1512 (b)(3)

- a. **Policy Position.** The American Hospital Association supports an amendment to Public Law 93-641 modifying the existing demographic quotas for membership on the boards of health systems agencies by substituting more general criteria which will assure the appointment of knowledgeable, qualified and interested individuals.
- b. **Rationale.** Planning is a judgmental process. Research and evaluation based on sound quantitative data can help to clarify the options available. But no amount of data can eliminate the need for planning agencies to exercise judgment in choosing among competing uses of resources. The critically important element in the effectiveness of the entire process is the calibre of the HSA board members who must in the final analysis make the difficult decisions.

It is appropriate that the law require consumer majorities on planning bodies. However, demands that social, economic, linguistic, and racial population of the area be proportionately represented on HSA boards have spawned confusion and litigation. Attempts to secure proportionate representation of all such groups have hampered efforts to assure widespread public participation in the selection of board and advisory group members and have sometimes created bodies that sacrifice sound decision making to demands for full participation. In some cases, it has seemed that board members were selected primarily to fill a numerical quota for a social or economic population rather than on the basis of merit and interest. Frequently, individuals selected have been unqualified as planners, uninformed about health care delivery, or preoccupied by personal interests. The process of selecting individuals primarily on the basis of their consumer advocacy background or to fill an ethnic quota must be replaced by a more systematic and deliberative process. The current requirements for HSA boards should be supplemented with criteria based on knowledge, record of community achievement, objectivity, expertise in health care delivery, and familiarity with community needs. For practical and political credibility, highly knowledgeable individuals must be selected.

It is, however, consistent with the intent of the statute and with practical necessities to mandate representation of the major types of providers who are affected by the planning process. The principal impact of the statute is intended to be upon providers of major institutional services -- for the most part, upon hospitals. To avoid turning the entire process into a confrontation between adversaries, it is essential that the views of those charged with administration of hospitals be represented on the planning boards. It should also be recognized that hospitals are themselves complex institutions in which many apparently diverse interests must be reconciled. No hospital can afford to ignore the needs and interests of its medical staff, its nurses, its technicians and other practitioners, its non-professional employees, or its patients. For these reasons, we have urged that the hospital representation on such boards be assured by statutory provisions.

The size of the HSA board membership may also tend to defeat or complicate planning. Current requirements state that an HSA governing board must have a minimum membership of 10 but that, if it has more than 30, an executive committee must be formed. A preliminary review indicates that more than half of these governing bodies have more than 30 members. Because of the difficulties in obtaining useful deliberations from large groups, these boards may be too cumbersome to function effectively or to promote a sense of individual responsibility. If the size of HSA boards were reduced, the quality of



deliberation and the resulting decisions might improve. In addition, capable individuals might be more inclined to accept appointment to small boards in which their participation would carry greater weight and individual contributions would receive greater recognition.

- c. Legislative Language. The following legislative language is proposed:

COMPOSITION OF HSA BOARDS  
Section 1512(b)(3)

"(3) Governing Body --

"(A) In General.--A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, have a governing body for health planning, which is established in accordance with sub-paragraph (C), which shall have the responsibilities prescribed by subparagraph (B), and which has exclusive authority to perform for the agency the functions described in Section 1513. Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, ~~except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an executive committee) composed in accordance with subparagraph (C) of not more than twenty-five members of the governing body and has delegated to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (2)(i) as the governing body is authorized to take.~~

\* \* \*

"(C) Composition: --The membership of the governing body and the executive committee (if any) of an agency shall be individuals who reside or have their principal place of business or employment in the health service area served by the agency, who are chosen on the basis of their knowledge and experience in the delivery of health care, their familiarity with the needs and interests of one or more communities within the health service area served by the agency, their objectivity, their record of achievement in the community and their sense of individual responsibility. Subject to the foregoing qualifications, efforts should be made to meet the following ~~requirements~~ goals for representation on the board or executive committee:

"(i) A majority (but not more than 60 per centum of the members) shall ~~be residents of the health service area served by the entity who are consumers of health care, and who are not (nor were within the twelve months preceding appointment been) providers of health care and who are broadly representative of the major social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care, including insurers who do not provide health care to the public or to their members, subscribers or policyholders directly or through subsidiaries or affiliates.~~



"(ii) ~~The remainder of the members shall be residents-of-the-health service-area-served-by-the-agency-who-are~~ providers of health care broadly representative of one or more of the following categories: (I) physicians (particularly practicing physicians), dentists, nurses, and other health professionals, (II) hospitals and other health care institutions (particularly ~~hospitals~~ such as long-term care facilities and health maintenance organizations), (III) ~~health-care-insurers~~, (IV) health professional schools, and (V) (IV) the allied health professions. Not less than one-third of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in Section 1531 (3)) and not less than one of whom shall represent hospital administration.

"(iii) The membership shall --

"(I) include (either through consumer or provider members) one or more public elected officials and other representatives of government authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health.

"(II) include a percentage of individuals who reside in non-metropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in non-metropolitan areas, and

"(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of Section 1310), include at least one member who is representative of such organizations).

"(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the representation on such subcommittee or group described in this subparagraph."

14. Indirect Providers of Health Care  
Section 1531(3)

- a. Policy Position. The American Hospital Association supports an amendment to restrict the definition of "indirect providers" to persons whose interests are closely allied to direct providers.
- b. Rationale. This amendment has the effect of shifting back into the consumer classification some individuals and organizations that are presently misclassified as providers, under the quotas established for planning agencies boards. We believe the statutory definition of "indirect provider" goes to an unwarranted extreme to assure that persons who are directly tied to the interests of health care services do not serve as "consumer" representatives. Persons, who are, in fact, non-providers with only coincidental or indirect ties to the health system and some who occasionally have direct conflicts with providers are presently included in the classification of "indirect providers." We urge that such persons and organizations should be qualified to serve as consumer representatives.

Accordingly, the American Hospital Association recommends that the definition of "indirect provider" not include (i) members of the immediate family of an indirect provider, (ii) any individual who receives less than one-quarter of his gross income from health care interest or direct providers, (iii) organizations which are basically concerned with education and research in aspects of particular diseases, such as the Heart Fund or the National Foundation, or (iv) insurers which do not provide health services to the public, either directly or through affiliates or subsidiaries.

- c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act to limit the definition of indirect provider:

INDIRECT PROVIDERS OF HEALTH CARE  
SECTION 1531(3)

"(3) The term 'provider of health care' means an individual --

\* \* \*

(B) who is an indirect provider of health care in that the individual --

(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II), ~~or~~ (IV) or (V) of clause (ii);

(ii) receives (~~either~~ directly but not ~~or~~ through his or her spouse or other family member) more than ~~one-tenth~~ one-quarter of his gross annual income from any one or combination of the following:

(I) Fees or other compensation for research into or instruction in the provision of health care;

(II) Entities engaged in the provision of health care or in which conduct such research or instruction, but not including entities which are engaged primarily in research and public education concerning special health issues or services or the detection, treatment and prevention of one or more specific diseases or physical disabilities.

(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research care.

(IV) Entities engaged in producing drugs or such other articles.

(V) Entities engaged in the provision of health care services to the public or to their members, subscribers or policyholders either directly or through subsidiaries or affiliates, including health maintenance organizations.

(iii) is a member of the immediate family of an individual described in subparagraph (A) ~~or in clause (i), (ii), or (iv) of subparagraph (B), or~~

~~(iv) is engaged in issuing any policy or contract of individual or group insurance or hospital or medical service benefits.~~

15. Appropriateness Review by Health Systems Agencies, Section 1513 (g)(1) and (2) Appropriateness Review by State Agencies, Section 1523(a)(6)
  - a. Policy Position. The American Hospital Association supports an amendment that would delete appropriateness review from the functions of Health Systems Agencies and State Health Planning and Development Agencies.
  - b. Rationale. We suggest that the appropriateness review sections in P.L. 93-641 are unnecessary and should be deleted from the law. Those sections have not yet been defined or developed by HEW regulations, a reflection on one of the difficulties that is created by this provision. No one has been able to come up with an acceptable definition of this function, nor have standards and guidelines been developed to assist HSAs and state agencies in implementing this function. In addition, many planning experts have expressed the viewpoint that HSAs and state agencies cannot effectively implement this provision.

Another problem is created by the fact that the law now requires that health systems agencies and state agencies individually review, on a periodic basis, each service and facility within the area of the state to determine their appropriateness. The magnitude of this burden can be appreciated when one considers that there are over 7,000 hospitals, many of which provide a broad range of services, over 22,000 nursing homes, and many other institutional providers, all of which would require appropriateness review. We believe that such a requirement adds an impossible burden on an already overworked process.

Congress incorporated this provision in P.L. 93-641 in an attempt to deal with the problem of duplicative facilities and services. It is our view that a more effective and comprehensive planning and certification of need process can serve as the mechanisms to eliminate unneeded facilities and services on a planned and rational basis. A sound preparation of health systems plans should include assessment of the appropriateness of facilities and services, not as a review function but as part of the planning process. The certificate of need function at the state level can also deal with this problem where it is determined to exist. Further, there are other legislative authorities that have a positive impact on the problem, e.g., PSRO, rate review, and utilization review at the hospital level. We therefore recommend the deletion of appropriateness review from the functions of health systems agencies detailed in Section 1513(g) and state health planning and development agencies as stated in Section 1523(a).

- c. Legislative Language. The following is the legislative language we propose to delete from the National Health Planning and Resources Development Act:

APPROPRIATENESS REVIEW BY HEALTH SYSTEMS AGENCIES  
SECTION 1513(g)(1) and (2)

~~"(g)(1)-Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and shall make recommendations to the State health planning and development agency designated under section 1521 for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services."~~

~~"(2)--A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 1515(e)."~~

APPROPRIATENESS REVIEW BY STATE AGENCIES  
SECTION 1523(a)(6)

~~"(6)--Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the State and, after consideration of recommendations submitted by health systems agencies under section 1513(g) respecting the appropriateness of such services, make public its findings."~~

\* \* \*

~~"(3)--A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health systems agency has made its recommendation under section 1513(g) with respect to the appropriateness of the service."~~

"(c) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), (6) or (7) of subsection (a) which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency."



16. Federal Hospital Construction Requirements  
Section 1602

- a. Policy Position. The federal government should develop a single set of codes and standards for the physical requirements of hospitals and other institutional providers of health care which would apply under all federal programs that stipulate compliance with facility codes and standards as requirements for participation, to which state and local governments should be encouraged to adhere as well.
- b. Rationale. The facilities in which hospital care or other institutional health care is provided are frequently subject to regulation from a multiplicity of agencies. State agencies are often granted such authority through certification or licensure laws, local authorities enforce building and sanitation codes, and federal agencies such as Medicare and the Federal Housing Authority often impose compliance with construction standards as a condition for participation in the program. These requirements are not always consistent with each other. In some cases, the institution may be able to conform to the more restrictive requirements, thus satisfying both, but in other cases it must decide which of the conflicting requirements will be satisfied, a decision usually based on the likely legal consequences of failure to satisfy the other.

This climate of multiple, often conflicting, codes has sometimes resulted in frustration and confusion, not only for the institutions, but also for architects, planning authorities and even the agencies which have adopted and are charged with enforcing the conflicting codes. Further complicating the situation is the fact that new codes are constantly under development and old ones are subject to frequent revisions. Different authorities having jurisdiction often enforce different revisions. Multiple codes produce added costs for institutions, which are ultimately passed on to their patients and third party payors.

The American Hospital Association believes that the federal government should take the lead in resolving this situation. First, the federal government should require that all federal programs that include codes and standards for physical facilities as requirements for participation should have consistent or identical standards. State and local authorities and voluntary accreditation or certification bodies should be urged to adopt the federal standards as their own. Even though there may be a demonstrated need for different emphasis in different parts of the country because of substantive geographical or environmental differences, these differences can generally be accommodated by permitting state and local authorities to impose additional but not conflicting, requirements or waivers to accommodate hazards or lack of hazards from earthquakes, hurricanes, blizzards and the like.

In development of uniform physical facility standards, maximum opportunity should be provided to all interested persons for input into the standardization of fire, safety, sanitary, electrical and other requirements. In addition, there is a need for a mechanism by which individual institutions can obtain determinations regarding appropriate requirements, use of equivalencies and adequate time allowances related to compliance with new codes. At any given time, many existing buildings are not in full compliance with all provisions of current codes. The differences between the standards met and the newest requirements are frequently small, but the cost of meeting the latest standards may be quite high, without commensurate benefit to the public interest. It must also be noted that the cheapest initial construction is not always the most economical, in view of maintenance and other operating costs which can

be raised substantially as a result of initial economies in design and construction.

- c. Legislative Language. The American Hospital Association supports the following amendment to the National Health Planning and Resources Development Act, adding a new Section 1602(b) to meet the above objectives.

"General Regulations

"Section 1602(a) The Secretary shall be regulation --

"(2) prescribe for medical facilities projects assisted under this title, general standards of construction, modernization, and equipment for medical facilities of different classes and in different types of location;

"(4) prescribe criteria for determining the extent to which existing medical facilities are in need of modernization;

"(b) In promulgating the regulations required by paragraphs (2) and (4) above, the Secretary shall --

"(1) Consult with and solicit recommendations and comments from (A) the agencies and other entities described in Section 1501(c) of title XV, (B) Federal and State agencies which have issued guidelines, recommendations, criteria, standards, or requirements respecting the physical aspects of medical facilities, (C) private entities which have promulgated standards, codes, or guidelines with respect to fire, infection, electrical or safety hazards, (D) the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association and any other private entities which have established voluntary licensure or accreditation standards for health care facilities.

"(2) Within six months of enactment hereof, issue proposed regulations which will give consideration to the recommendations provided by the entities listed in (1) and which are capable of being adopted by all such agencies as uniform standards for the construction, modernization and equipment of medical facilities, whether or not such facilities are eligible for assistance under this title. Such proposed regulations shall allow a reasonable time for submission of comments by the public and the entities listed in (1).

"(3) Within one year after the date of enactment hereof, issue final regulations.

"(4) Urge adoption of the regulatory standards for construction, modernization and equipment by all agencies and entities listed in (1) to the fullest extent practicable. Such adoption shall be mandatory for

all Federal agencies identified in (1) above, including without limitation, the Federal Housing Authority, the Occupational Safety and Health Administration, the Veterans Administration, the Public Health Service and the Indian Health Service.

"(5) Such standards shall make provision for the imposition by State and local agencies of additional or higher standards deemed necessary to meet substantially different local geographic or environmental conditions, such as susceptibility to earthquakes, floods and other natural phenomena, but no other inconsistent or more restrictive standards shall be imposed upon any project which is eligible for assistance under this title.

"(6) Require, to the maximum extent feasible, joint or consolidated inspection and enforcement activities by all entities described in (1).

"(7) Provide in such regulations for the issuance of advisory determinations concerning compliance with the requirements through the use of equivalencies and alternatives. Such regulations shall state specifically the degree to which existing facilities shall be required to meet new requirements and standards and shall establish appropriate time allowances for achieving such compliance. The regulations shall specify the degree to which modernization projects shall be required to meet the requirements and standards for new construction.

"(8) Provide for review on a periodic basis (but at least every three years) of the standards and requirements contained in such regulations.

17. Provision of Free Care  
Section 1604(b)(1)(J)

- a. **Policy Position.** The American Hospital Association supports an amendment to clarify the obligations of health care institutions which receive certain federal funds.
- b. **Rationale.** The purpose of this amendment is to make more reasonable the obligation of health care institutions which receive certain federal funds to make health care available to patients unable to pay.

The amendment requires that such facilities provide reasonable assurance for such health care for a period of 20 years after the approval of their funding applications if a grant, or the length of time of the loan or loan guaranteed assistance. It also limits the facility's obligation to those persons residing or employed within its service area. Finally, the amendment makes enforcement of this obligation a responsibility of the State Agency under the terms of its agreement with the Secretary, as is the case with other provisions of this part of the Act.

While hospitals have provided and will continue to provide services to individuals unable to pay for care, the accountability for providing a reasonable volume of uncompensated services in section 1604(b)(1)(g)(ii) should be limited to the existing 20 year period for the recovery of assistance funds found under Title VI of the Public Health Service Act.

- c. **Legislative Language.** The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy.

PROVISION OF FREE CARE  
SECTION 1604 (b)(1)(J)

"(J) reasonable assurance that ~~at all times~~ for a period of twenty years after such application is approved if a grant, for the length of time of the loan or loan guarantee assistance, (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed ~~in the area served by~~ the facility's service area and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the ~~Secretary~~ State agency, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint."

18. Planning Grants for Health Systems Agencies  
Section 1516(b)(1), (2)(B), and (3)

- a. **Policy Position.** The American Hospital Association supports an amendment to increase funding for fully designated and conditionally designated Health Systems Agencies.
- b. **Rationale.** We support an amendment that would increase the minimum amount a Health Systems Agency (HSA) receives for full designation and to specify that conditionally designated Health Systems Agencies are to be funded at the same levels as fully designated Health Systems Agencies. We would encourage that the amount to be awarded per person per year be increased from 50¢ to 55¢ during the fiscal year 1978, from 55¢ to 60¢ during the fiscal year 1979, and from 60¢ to 70¢ during the fiscal year 1980. These changes would reflect inflationary costs, for a total amount of \$4,500,000 unless the agency would receive a greater amount based upon population. In addition, we propose that the amount of a grant for a Health Systems Agency may not be less than \$185,000, an increase from the proposed \$175,000 (again, to reflect inflation). The purpose of the amendment is to ensure that Health Systems Agencies conditionally designated are able to perform in an effective manner. We strongly recommend that appropriations for this activity be considered in the light of a new program, which is in a critical stage of development. We urge that funding levels provide the necessary resources for the sound development of this program across the country.
- c. **Legislative Language.** The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

PLANNING GRANTS FOR HEALTH SYSTEMS AGENCIES  
SECTION 1516(b)(1), (2)(B), and (3)

"(b)(1) The amount of any grant under subsection (a) to a health systems agency designated under section 1515(b) shall be determined by the Secretary ~~The amount of any grant under subsection (a) to any health systems agency designated under section 1515(e)~~ and shall be the lesser of --

"(A) the product of ~~\$0.50~~ \$0.55 during the fiscal year 1978, \$0.60 during the fiscal year 1979, and \$0.70 during the fiscal year 1980 and the population of the health service area for which the agency is designated, or

"(B) ~~\$3,750,000~~, \$4,500,000,

unless the agency would receive a greater amount under paragraph (2) or (3).

\* \* \*

"(2) (B) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by subparagraph (A) shall --

"(i) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or ~~support~~ operation of health resources of the kind that may be within the purview of the agency's functions under subsections 1513(e), (f), and (g), and

"(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to



the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

"(3) The amount of a grant under subsection (a) to a health systems agency designated under section 1515(e) may not be less than \$175,000 \$185,000 during the fiscal year 1978, \$195,000 during the fiscal year 1979, and \$205,000 during the fiscal year 1980."

19. Private Contributions to Health Systems Agencies  
Section 1512(b)(5)

- a. Policy Position. The American Hospital Association supports an amendment to increase funding for Health Systems Agencies by permitting a broadened base of non-federal funds for Health Systems Agencies activities.
- b. Rationale. The purpose of this amendment is two-fold: First to allow Health Systems Agencies (HSAs) to receive additional matching federal funds and second, to permit a broadened scope of non-federal funds that can be used by the Health Systems Agencies for accomplishing their work programs. As an alternative to the severe limitations now stated in the law, there should be a clarification as to the sources from which a Health Systems Agency cannot accept contributions because of possible benefit from an agency action. Also, if the legislation were changed to read substantial funds or contributions of services, this would have the effect of broadening the funding base without jeopardizing the Health Systems Agency's actions. It would permit more adequate funding for Health Systems Agency operations.

Every effort should be made to provide for the success of Health Systems Agencies, to further develop the planning process. If only federal funds are to be used, many Health Systems Agencies will not have adequate staff to perform all of their mandated functions.

- c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

PRIVATE CONTRIBUTIONS TO HEALTH SYSTEMS AGENCIES

SECTION 1512(b)(5)

"(5) PRIVATE CONTRIBUTIONS.--No health systems agency may accept more than ten percent (10%) of its operating budget or more than \$25,000 in any funds or contributions of services (other than processed data) or facilities from any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support operation of health resources within the purview of the agency under subsections 1513(e), (f), and (g) unless, in the case of an entity, it is an organization described in section 509(a) of the Internal Revenue Code of 1954 and is not directly engaged in the provision of health care in the health service area of the agency. No health systems agency may accept in the aggregate from all such individuals, associations and private entities more than twenty-five percent (25%) of its operating budget. For purposes of this paragraph, an entity shall not be considered to have such an interest solely on the basis of its providing (directly or indirectly) health care for its employees or health insurance benefits for enrolled subscribers."

20. Uniform Cost Accounting and Reporting Systems  
Section 1533(d) and 1502(9)

- a. **Policy Position.** The American Hospital Association opposes the establishment of mandatory uniform accounting requirements, but supports uniform reporting of costs, rates and services.
- b. **Rationale.** Section 1533(d) of the National Health Planning and Resources Development Act calls for the establishment by the Secretary, of uniform systems for cost accounting, establishment of rates, classification of institutions and cost reporting. In the last session of Congress the implementation of a uniform reporting system along with a method of reconciliation the health care institutions' internal accounting systems to the reporting system were enacted through Section 19(a) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, codified as Section 1121 of the Social Security Act. Since the enactment of this legislation puts in place national systems of Reporting and Reconciliation, this Association believes the need for the continuation of the intent of Section 1533(d) and 1509(a) is no longer necessary or applicable.

It should be noted that the Association supports the establishment of uniform reporting forms so that health planning and cost reimbursement agencies are enabled to make equitable and valid comparisons among institutions and to design better reimbursement methods and systems. Although uniform accounting might seem theoretically desirable, a mandated system which lacks flexibility when applied to local situations cannot be implemented without impairing management responsibility and accounting innovation. Whenever uniform accounting has been required for an industry, it has been accompanied by an inevitable lag between development of new financial techniques, accounting principles and management information needs. The importance of a flexible accounting system, which will enable institutions to continue to adhere to generally accepted accounting principles as they evolve, cannot be overemphasized. Therefore, the Association supports uniform reporting of costs and services, but does not support extension of that principle to the requirement of uniform accounting for all institutions.

Uniform reporting, and classification can be, and are acceptable concepts since they need not affect internal accounting systems and management prerogatives in obtaining desired results. The necessary requisite to uniform reporting need only be an adequate method of reconciliation, for conversion of internal accounting information into a uniform reporting system. This does not necessitate uniform accounting. As indicated, both systems--uniform reporting and a system of reconciliation--have already been directed by Congress in its last session.

The American Hospital Association, therefore, recommends that Section 1533(d) be amended to be consistent with Section 19(a) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, codified as Section 1121 of the Social Security Act. In addition, we recommend amendment of Section 1502(9) to also be consistent with the new Section of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, codified as Section 1121 of the Social Security Act.

- c. Legislative Language. The following is the legislative language proposed for Section 1502(9) and 1533(d):

UNIFORM COST-ACCOUNTING-AND REPORTING SYSTEMS  
SECTION 1502(9)

"(9) The adoption of ~~uniform-cost-accounting, simplified-reimbursement, and-utilization-reporting-systems-and~~ improved management procedures and uniform systems for reporting utilization, costs and rates of Section 1121 of the Social Security Act.

SECTION 1533(d)

Note: Delete all of present Section 1533(d) and substitute the following:

"(d) The Secretary shall, by regulation, implement in accordance to Section 19(a) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, codified as Section 1121 of the Social Security Act, uniform reporting systems for health services facilities and organizations.

21. Prohibition Against Purchasers of Health Care Being Designated as Health Systems Agency  
Section 1512(b)(1)

- a. Policy Position. The American Hospital Association supports an amendment to P.L. 93-641 which would eliminate the possibility that a major purchaser or provider of health services could be appointed to act as a health systems agency, thus avoiding a potentially major conflict of interest.
- b. Rationale. The National Health Planning and Resources Development Act of 1974 currently permits designation as health systems agencies of not-for-profit corporations, public regional planning bodies or units of local government. Entities which are or operate educational institutions are prohibited from being so designated.

Many units of local government are major providers or purchasers of health care, frequently operating municipal or county hospitals or being charged with responsibility for administering and funding Medicaid or welfare programs under which health services are provided to segments of the population. If such government agencies should be appointed as health systems agencies or be allowed to control health systems agencies, a serious conflict between their interest as planners and their interest as purchasers of health care would result. Clear indication is provided in the statute that Congress did not intend this result; a multitude of safeguards are provided to ensure that health systems agencies would not be dominated by provider or purchaser interests.

American Hospital Association proposes that the statute be amended to prohibit local government agencies and private organizations that are major purchasers or providers of health care from being designated as health systems agencies. This will prevent the possibility that decisions about resource allocations will be made by those with vested interest in the outcomes.

- c. Legislative Language. The following legislative language is proposed:

"Health Systems Agencies  
\* \* \*

"Sec. 1512. .

"(b)(1) Legal Structure.--A health systems agency for a health service area shall be --

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or



public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State Law (in effect before the date of enactment of this subsection) to carry out health planning and review functions such as those described in Section 1513, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution, nor may a health systems agency be a substantial purchaser or provider of health care nor control or operate an entity which is a substantial purchaser or provider of health care.

2  
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22. Coordination between HSAs and Health Care Institutions.  
Section 1513

- a. Policy Position. American Hospital Association supports amendments to the National Health Planning and Resources Development Act which will encourage coordination between the internal planning efforts of health care institutions and the areawide comprehensive health planning conducted by health systems agencies, with particular emphasis on development of alternate modes of health care delivery.
- b. Rationale. Experience has demonstrated that effective health planning requires extensive cooperation between the public planning agencies and the institutions whose future existence and activities are being planned. National health policy should encourage both agencies and institutions to recognize that planning is the exclusive responsibility of neither. Results for both are often directly proportional to the degree of such cooperation. Health care institutions can benefit substantially from an effective regulatory planning process because they can base their individual expectations on what will occur on a system wide basis. Then, as institutional staffs become better able to plan and manage their internal operations, the HSAs will be freed of detailed project planning that institutions can perform more efficiently and will be able to devote more time and attention to the broader and more complex issues of coordination of community resources.

Health care institutions frequently lack knowledge of planning regulations. Perhaps because of this, some hospital administrators and health professionals do not have a positive orientation towards planning. On the other hand, many health planners are well equipped with theoretical training and methods, but lack practical experience in the management and delivery of health care resources. The public, as well as both organizations, will receive material benefits from increasing cooperation between institutions and agencies in the development of health plans, even in instances in which their conclusions may differ.

Cooperative planning by institutions and HSAs is possibly the best way of encouraging development of alternative approaches to cost and quality effectiveness in delivery of health care services. Perceptions of health care services should not become so closely tied to the traditional structures and functions as to preclude opportunities for adaption to changing conditions and provision of needed community health services in new ways.

The HSA should determine what services and facilities are necessary to achieve the most effective and efficient levels and scope of health care for the health service area, within local resource limitations. The responsibility of any HSA, however, must stop short of determining how such services should be administered and how such facilities should be managed. Hospital managers, trustees and medical staffs are best able to evaluate the needs and capabilities of their institutions and assess actions for improving them. Regulations enforced by the HSA should provide freedom for the exercise of management prerogatives to attain planning objectives.

To achieve the foregoing objectives, the American Hospital Association supports amendments to the National Health Planning and Resources Development Act which will encourage cooperation between HSAs and health care institutions, especially in the development of alternative modes and methods of delivery of health services.

- c. Legislative Language. The following is proposed legislative language to amend the statute in accordance with the above policy:

COORDINATION OF PUBLIC AND INSTITUTIONAL PLANNING  
SECTION 1513

"(d) Each health systems agency shall coordinate its activities with--

"(1) each Professional Standards Review Organization (designated under Section 1152 of the Social Security Act),

"(2) entities referred to in paragraphs (1) and (2) of Section 204(a) of the Demonstration Cities and Metropolitan Development Act of 1966 and regional and local entities the views of which are required to be considered under regulations prescribed under Section 403 of the Intergovernmental Cooperation Act of 1968 to carry out Section 401(b) of such Act,

"(3) Other appropriate general or special purpose regional planning or administrative agencies, and

"(4) any other appropriate entity, including entities which provide institutional health services.

in the health system agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such entities which alter the area's health system will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities.

"(i) Nothing in this title shall be construed to authorize any Federal or State officer or employee or the officer or employee of any health systems agency to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person."

Mr. ROGERS. Thank you, Mr. McMahon, for a very helpful statement, and we will be pleased to receive your specific language suggestions which would carry out your thoughts.

There is a call to the floor for a vote. I think if members could vote and return quickly, it would probably be the best procedure to follow at this time.

We will recess for 10 minutes. We are sorry to have to interrupt. The committee stands in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please.

We are delighted now to hear from Mr. Bromberg.

Your statement will be made a part of the record in full [see p. 993]. If you could highlight it for us, as Mr. McMahon just highlighted his, that would be helpful to the subcommittee.

#### STATEMENT OF MICHAEL D. BROMBERG

Mr. BROMBERG. I will try to do that.

I am Michael D. Bromberg, executive director of the Federation of American Hospitals. Accompanying me today is Robert J. Sam- sel, president of the Federation and vice president for Management Services and Marketing, Community Psychiatric Centers, Inc., of Santa Ana, Calif.

The Federation represents the more than 1,000 investor-owned hospitals and our member hospital management companies now manage under contract approximately 200 additional hospitals including teaching, religious, community nonprofit and public institutions.

We have supported the Planning Act since its passage, that concept that called for a clear preference of determination of needs at the State and local level not in the Department of HEW.

We have not changed our position in support of Public Law 93-641 and we recommend a 3-year extension of the Health Planning Act notwithstanding efforts by the Department of HEW to strain its interpretation of the law to control and regulate every aspect of the planning process. The Chairman and members of the subcommittee deserve special credit for defending the original intent of Congress that Federal health planning guidelines not be allowed to override the health needs of local areas. We do remain concerned that Government, faced with budgetary pressures, will continue efforts to arbitrarily control costs without adequate consideration of the quality health resources required in individual State or communities.

In order to preserve the bottom-up development of appropriate health plans based on local requirements, we urge amendments to Public Law 93-641 designed to clarify the scope of national guidelines on health resources and utilization. We recommend specifically the deletion of the requirement in section 1513(b) (2) of the act that health systems plans "be consistent with" the national guidelines, retaining the requirement that HSA's "take into account" those national guidelines.



The process for determining needed local health resources established by Public Law 93-641 must be given a reasonable opportunity for success and that requires Federal assistance, but without bureaucratic roadblocks. HSA's are still in the development state and consequently they are particularly vulnerable to Federal pressures and proposals for substantial expansion of their responsibilities. We urge amendments to Public Law 93-641 which will help HSA's meet the responsibilities already assigned to them in a fair and equitable process and we caution against expansion of their duties or illusions about unlimited cost savings without sacrificing quality of health care.

We advocate strengthening the capability of the local health system agencies by assuring that full financial support is provided by federally appropriated funds, as authorized in the law. This would permit the agency to attract experienced, qualified, and professionally trained staff personnel, able to understand the economic, financial, and administrative complexities of providing health services and institutional health care within the availability of health manpower and health facilities resources.

We support a 3-year extension of the Health Planning Act and offer the following comments on the proposed Health Planning Act Amendments of 1978, contained in H.R. 10460.

We endorse those provisions of section 209 which require inclusion on HSA governing bodies of elected officials and others broadly representative of the area. We urge expansion of this section to require inclusion of hospital representatives broadly representative of institutions in the area. The expertise of those knowledgeable in hospital administration is a necessary resource for governing board representation on a body charged with major responsibilities for making decisions on appropriate capital expenditures by hospitals. Hospital representation on an HSA executive committee should also be required.

We endorse section 215 which adds to the list of expertise which must be present on an HSA staff in financial and economic analysis. Health economists are needed by HSA's to properly assess projected population, industry, demographic, and economic trends and to interpret and translate the dynamics of change into impact on existing and future health services and facilities.

HSA staff should also have experience in hospital fiscal matters including reimbursement and budget issues.

It is imperative that the certificate-of-need responsibilities of State agencies and HSA's be met with continuing regard for due process of law. We urge the subcommittee to clarify the availability of judicial review following an adverse decision by the State agency.

The expansion of certificate-of-need coverage under section 218 to major medical equipment, regardless of location, raises several questions ranging from the degree of government intervention in the private practice of medicine to competitive advantages granted to certain types of providers.

On page 9 we try to make the point that where the process does not cover a particular class of providers, whether a physician's



office, HMO, or anyone else, the resources required and controlled by exempt providers not be counted in the determination of institution needs. We support the Chairman's approach to treat HMO's and physicians offices alike.

We also strongly urge the subcommittee to amend H.R. 10460 to specifically require Federal hospitals to comply with the same certificate-of-need requirements applicable to non-Federal providers.

We are concerned with section 1527(a)(3), which directs that a certificate of need be withdrawn if it is determined on an annual review that adequate progress has not been made. "Adequate progress" is a vague term which should be changed to reflect "good faith efforts to commence or continue the authorized project." Progress can be blocked by Government, a striking construction union, or by others over whom the recipient of a certificate has no control.

On page 11 we endorse the definition of capital expenditure in section 218 and specifically the exclusion of simple acquisitions which do not involve changes in services or the number of hospital beds. The purpose of certificate of need laws is to approve new construction or the acquisition of new equipment and not to hinder the transfer of property rights. This change will also facilitate mergers, shared services, and the growth of multifacility systems.

We oppose section 218(b)(4) which changes the maximum review period for certificate-of-need applications from 90 days to 1 year. We support the consideration of competing applications at the same time, but see no justification for a 1-year delay in the decisionmaking process. In effect, this amendment encourages a 1-year moratorium on capital which could adversely impact on quality of care and increase costs by delaying projects to a period of higher inflation.

On page 12 we discuss appropriateness review.

Section 219(b) requires each State to have in place within 4 years a program which in effect decertifies inappropriate services. This directive begs the complex legal and economic issues involved in terminating health services or closing health facilities. We believe that any decertification program should be voluntary and carefully tested on a limited basis. When a facility or service is voluntarily decertified, it should receive payment equal to the fair value of the property to recognize debt and equity. Assurances should also be made to provide for employees who lose their jobs and to provide access to comparable care for displaced patients.

While we support experimentation with voluntary decertification, we also believe that the potential cost savings from hospital bed reduction have been grossly exaggerated. A well-managed institution will not incur substantial costs for maintaining empty beds beyond the interest payments and amortization of the debt.

A major reason for the high cost of maintaining some empty beds has been the cost reimbursement system which provides no incentive for efficient management of the personnel and other viable costs which should not be incurred for most empty beds.

For these reasons, the closing of some beds within a hospital will save little or no money; however, the closing or conversion of an entire institution can have a significant impact. We would recom-

mend that any experiment in voluntary decertification assign a priority to the closing or conversion of entire hospitals, rather than partial closings and that cost savings in such experiments be carefully analyzed before a more comprehensive decertification program is undertaken.

In addition to our comments on H.R. 10460, we offer the following suggestions for strengthening the planning process:

First, HSA's should be required to solicit competitive applications for needed services, equipment, and facilities in order to stimulate competition and lower costs.

Second, certificate-of-need agencies should be required to select the most cost effective of acceptable applications for needed services, equipment, and facilities.

Third, the definition of capital expenditures in section 1122 of Public Law 92-603 for medicare purposes and the definition for certificate of need under Public Law 93-641 should be consistent. We urge the Congress to raise the \$100,000 threshold in section 1122 to \$150,000, making it consistent with the Health Planning Act. In addition, we recommend that the dollar threshold be adjusted annually by an economic index reflecting general inflation factors.

Fourth, exempt replacement of equipment, plant maintenance, and capital expenditures mandated by law from the certificate-of-need process.

In conclusion we support the general approach of H.R. 10460 and urge the adoption of those amendments designed to assure fairness and objectivity in the certificate-of-need process, and improve funding and qualified staff, in order to strengthen the health planning process.

Thank you.

[Testimony resumes on p. 1010.]

[Mr. Bromberg's prepared statement and attachment follow:]

STATEMENT OF  
MICHAEL D. BROMBERG, ESQ., EXECUTIVE DIRECTOR  
AND  
ROBERT J. SAMSEL, PRESIDENT  
FEDERATION OF AMERICAN HOSPITALS  
BEFORE THE  
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT  
OF THE  
HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE  
ON H. R. 10460  
THE HEALTH PLANNING AND RESOURCES  
DEVELOPMENT ACT OF 1978  
FEBRUARY 2, 1978

Mr. Chairman and Members of the Subcommittee, I am Michael D. Bromberg, Executive Director of the Federation of American Hospitals. Accompanying me today is Robert J. Samsel, President of the Federation and Vice President for Management Services and Marketing, Community Psychiatric Centers, Inc. of Santa Ana, California.

The Federation represents the more than 1,000 investor-owned hospitals and our member hospital management companies now manage under contract approximately 200 additional hospitals including teaching, religious, community non-profit and public institutions.

Prior to and during the Congressional debate which lead to enactment of P. L. 93-641, the Federation endorsed the establishment of a network of health systems agencies and state certificate of need laws designed to assure sound health planning at the state and local levels. Our organization supported P. L. 93-641 in general at the time of its enactment and has supported the basic concept of that law since that time. That concept, as we understand it, embodied a clear preference for determination of need at the state and local levels, not in the Department of Health, Education, and Welfare.

We have not changed our position in support of P. L. 93-641 and we recommend a three year extension of the Health Planning Act notwithstanding efforts by the Department of HEW to strain its interpretation of the law to control and regulate every aspect of the planning process. The Chairman and Members of the Subcommittee deserve special credit for defending the original intent of Congress that federal health planning guidelines not be allowed to override the health needs of local areas. We remain concerned that government, faced with budgetary pressures, will continue efforts to arbitrarily control costs without adequate consideration of the quality health resources required in individual states or communities.

#### Development of Health Plans

In order to preserve the basic concept of bottom-up development of appropriate health plans based on local requirements, we urge amendments to P. L. 93-641 designed to clarify the scope of national guidelines on health resources and utilization. We recommend the deletion of the requirement in Section 1513(b)(2) of the Act that health systems plans "be consistent with" the national guidelines, retaining the requirement that HSAs "take into account" those national guidelines. In addition, we recommend adoption of H. R. 10251, sponsored by Congressman Baucus, which establishes a procedure for Congressional



veto of national guidelines promulgated by the Secretary of HEW.

The Federation's primary concerns with the initial process in developing proposed national guidelines include:

(1) The "in the closet" method by which they were developed and the timing of their distribution by the Department: The law specifically requires the Secretary to "consult with, and solicit recommendations and comments from the health systems agencies . . . , state health planning and development agencies . . . , Statewide health coordinating councils . . . , associations and specialty societies, representing medical and other health care providers, and the National Council on Health Planning and Development . . ."

The date the first proposed guidelines were published in the FEDERAL REGISTER, September 23, 1977, was coincidentally the first meeting of the fully constituted National Health Planning Council, whose members were furnished copies of the proposals concurrent with distribution to the public. Failure of the Secretary to appoint the Council earlier and to consult with them certainly makes suspect the dedication of the Secretary to carry out the intent of Congress with respect to the development of such guidelines.

(2) The inflexibility of the proposed guidelines on local Health Systems Agencies: Health Systems Plans must "be consistent with" the guidelines "where they establish goals and set forth plans not in excess of the level set forth in the guidelines where that level is stated as a maximum, or not less than the level set forth in the guidelines where that level is stated as a minimum except where specific exceptions are provided in the guidelines." Failure to comply would result in disapproval of the Health System Plan and ultimate loss of status and operating funds for the health planning agency. An illustration of both the inflexibility of the proposed guidelines and the misuse of findings of research by HEW concerns the 4.0 beds per 1,000 requirement.

The major study was that done by the Institute of Medicine, National Academy of Science, Washington, D. C., entitled "Controlling the Supply of Hospital Beds" and dated October 1976. The following is quoted from Page ix of the study:

"The committee recommends that a national health planning goal be established . . . to achieve an overall reduction of at least 10 percent in the ratio of short term hospital beds to the population within the next five years . . . this would mean a reduction from the current national average of approximately 4.4 non-federal short term general hospital beds per 1,000 population to a national average

of approximately 4.0 in five years  
 . . . the national goals should be applied flexibly (emphasis added) to meet varying conditions and circumstances in each state and in the health service areas within the state . . ."

(3) The use of specific quantitative guidelines and formulas: The Federation reiterates its position that whenever specific numbers and formulas are included in guidelines, that such standards should be considered and adapted to the conditions and unique needs of the local areas. To mandate conformance without permitting local consideration and adaptation imposes federal control, which as we interpret the statute and understand the intent of Congress, was not intended.

For these reasons we urge modification of P. L. 93-641 to require Health Systems Agencies to take into account the national guidelines, but that Congress repeal the requirement that health systems plans "be consistent with" national guidelines.

The process for determining needed local health resources established by P. L. 93-641 must be given a reasonable opportunity for success and that requires federal assistance, but without bureaucratic roadblocks. HSAs are still in the developmental state and consequently they are particularly vulnerable to federal pressures and proposals for substantial expansion of their responsibilities. We urge amendments to P. L. 93-641 which will

help HSAs meet the responsibilities already assigned to them in a fair and equitable process and we caution against expansion of their duties or illusions about unlimited cost savings without sacrificing quality of health care.

We advocate strengthening the capability of the local health system agencies by assuring that full financial support is provided by federally appropriated funds, as authorized in the law. This would permit the agency to attract experienced, qualified and professionally trained staff personnel, able to understand the economic, financial, and administrative complexities of providing health services and institutional health care within the availability of health manpower and health facilities resources.

We support a three year extension of the Health Planning Act and offer the following comments on the proposed Health Planning Act Amendments of 1978, contained in H. R. 10460.

#### Revision of National Guidelines

Section 201 of H. R. 10460 requires the Secretary to review the goals and standards established for health planning on an annual basis. We recommend that this requirement be changed to direct revision of the goals and standards at least once every two years. This would assure a more deliberative process with greater "prior consultation" with state and local planning

authorities, industry groups, and the National Council on Health Planning and Development.

We endorse the requirement that revised national goals and standards be based on plans developed at the state and area-wide levels.

#### Contributions to HSAs

We oppose Section 208 which would permit HSAs to accept financial support from insurers. Other provisions of H. R. 10460 take great pains to guard against conflicts of interest and we believe funding of HSAs should be accomplished without involving those who are part of the local decision making process. We would oppose provider contributions to HSAs for similar reasons.

#### Membership Requirements

We endorse those provisions of Section 209 which require inclusion on HSA governing bodies of elected officials and others broadly representative of the area. We urge expansion of this section to require inclusion of hospital representatives broadly representative of institutions in the area. The expertise of those knowledgeable in hospital administration is a necessary resource for governing board representation on a body charged with major responsibilities for making decisions on appropriate capital expenditures by hospitals. Hospital representation on an HSA executive committee should also be required.



Staff Expertise

We endorse Section 215 which adds to the list of expertise which must be present on an HSA staff expertise in financial and economic analysis. Health economists are needed by HSAs to properly assess projected population, industry, demographic, and economic trends and to interpret and translate the dynamics of change into impact on existing and future health services and facilities.

HSA staff should also have experience in hospital fiscal matters including reimbursement and budget issues.

Certificate of Need Programs

It is imperative that the certificate of need responsibilities of state agencies and HSAs be met with continuing regard for due process of law. We urge the Subcommittee to clarify the availability of judicial review following an adverse decision by the State Agency.

Expansion of Certificate of Need

The expansion of certificate of need coverage under Section 218 to major medical equipment, regardless of location, raises several questions ranging from the degree of government intervention in the private practice of medicine to competitive advantages granted to certain types of providers.

The aspect of this debate which has the greatest impact upon our hospitals is the manner in which certificate of need agencies define existing resources. If a particular piece of expensive equipment is located in a physician's office or within an HMO ambulatory care facility, but is not located in any hospital in the community, will an institution's application for a certificate of need be judged by existing institutional resources or by existing resources of any type regardless of location? Hospital patients should not be denied a needed service within the institution on the grounds that an HMO, to which they do not belong, or a doctor, who is not their personal physician, has that particular service or technology.

If the certificate of need process does not cover a particular class of provider, then resources acquired and controlled by those exempt providers should not be counted in the determination of institutional needs.

In addition, while we have supported the federal HMO Acts and continue to favor HMO development as part of a competitive pluralistic system of delivering health care, we do not believe that favored treatment in the certificate of need process is necessary or desirable. The conflict of interest provisions of H. R. 10460, which we endorse, should be adequate to

disqualify competitors from voting on HMO applications for capital expenditure approval.

We also strongly urge the Subcommittee to amend H. R. 10460 to specifically require federal hospitals to comply with the same certificate of need requirements applicable to non-federal providers.

We are concerned with Section 1527(a)(3), which directs that a certificate of need be withdrawn if it is determined on an annual review that adequate progress has not been made. "Adequate progress" is a vague term which should be changed to reflect "good faith efforts to commence or continue the authorized project." Progress can be blocked by government, a striking construction union, or by others over whom the recipient of a certificate has no control.

We also urge deletion or modification of Section 1527(a)(4) which requires that a certificate of need shall specify the maximum amount of the capital expenditure which may be obligated. This requirement could have an adverse impact on investments where delays beyond control of the holder of a certificate and resulting inflation cause minor cost increases which in turn force further delays in applying for a new certificate.

Section 1527(a)(6) requires that decisions of the state certificate of need agency be consistent with the state health plan. We recommend more flexibility to assure that special needs of a local area are taken into account and can take precedence over predetermined state goals.

We endorse the definition of capital expenditure in Section 218 and specifically the exclusion of simple acquisitions which do not involve changes in services or the number of hospital beds. The purpose of certificate of need laws is to approve new construction or the acquisition of new equipment and not to hinder the transfer of property rights. This change will also facilitate mergers, shared services, and the growth of multi-facility systems.

We oppose Section 218(b)(4) which changes the maximum review period for certificate of need applications from 90 days to one year. We support the consideration of competing applications at the same time, but see no justification for a one year delay in the decision making process. In effect, this amendment encourages a one year moratorium on capital which could adversely impact on quality of care and increase costs by delaying projects to a period of higher inflation.

Section 218(b)(6) requires that the efficiency and appropriateness of existing services and facilities be considered in the review process. We are concerned

that this criteria not be interpreted to deprive consumers of access to modern facilities or needed services as a punishment against existing substandard, antiquated facilities in the area which do not plan to upgrade plant or services. In addition, we urge the Subcommittee to specify that the burden of analyzing the efficiency and appropriateness of existing services and facilities rests with the HSA staff and not with the applicant.

#### Appropriateness Review

Section 219(b) requires each state to have in place within four years a program which in effect decertifies inappropriate services. This directive begs the complex legal and economic issues involved in terminating health services or closing health facilities. We believe that any decertification program should be voluntary and carefully tested on a limited basis. When a facility or service is voluntarily decertified, it should receive payment equal to the fair value of the property to recognize debt and equity. Assurances should also be made to provide for employees who lose their jobs and to provide access to comparable care for displaced patients.

While we support experimentation with voluntary decertification, we also believe that the potential cost savings from hospital bed reduction have been



grossly exaggerated. A well managed institution will not incur substantial costs for maintaining empty beds beyond the interest payments and amortization of the debt.

A major reason for the high cost of maintaining some empty beds has been the cost reimbursement system which provides no incentive for efficient management of the personnel and other variable costs which should not be incurred for most empty beds.

For these reasons, the closing of some beds within a hospital will save little or no money; however, the closing or conversion of an entire institution can have a significant impact. We would recommend that any experiment in voluntary decertification assign a priority to the closing or conversion of entire hospitals, rather than partial closings and that cost savings in such experiments be carefully analyzed before a more comprehensive decertification program is undertaken.

In addition to our comments on H. R. 10460, we offer the following suggestions for strengthening the planning process:

- (1) HSAs should be required to solicit competitive applications for needed services, equipment, and facilities in order to stimulate competition and lower costs.

- (2) Certificate of need agencies should be required to select the most cost effective of acceptable applications for needed services, equipment, and facilities.
- (3) The definition of capital expenditures in Section 1122 of P. L. 92-603 for Medicare purposes and the definition for certificate of need under P. L. 93-641 should be consistent. We urge the Congress to raise the \$100,000 threshold in Section 1122 to \$150,000 making it consistent with the Health Planning Act. In addition, we recommend that the dollar threshold be adjusted annually by an economic index reflecting general inflation factors.
- (4) Exempt replacement of equipment, plant maintenance, and capital expenditures mandated by law from the certificate of need process.

#### Conclusion

We support the general approach of H. R. 10460 and urge the adoption of those amendments designed to assure fairness and objectivity in the certificate of need process, and improve funding and qualified staff, in order to strengthen the health planning process.

SUMMARY OF RECOMMENDATIONS

BY

FEDERATION OF AMERICAN HOSPITALS

ON H. R. 10460

THE HEALTH PLANNING AND RESOURCES

DEVELOPMENT ACT OF 1978

FEBRUARY 2, 1978

(1) We recommend a three year extension of P. L. 93-641.

(2) We urge that HSAs be required to take into account the national health guidelines, but that Congress repeal the requirement that health systems plans "be consistent with" national guidelines.

(3) We endorse the requirement that revised national goals and standards be based on plans developed at the state and area-wide levels, but we recommend that revision be required every two years, not annually to assure greater "prior consultation" with interested groups.

(4) We oppose contributions to HSAs from any organizations with financial interest in the planning process, including insurers and providers.

(5) We support the requirement that elected officials and others broadly representative of the area be included on HSA governing bodies and we urge expansion of this requirement to include hospital representatives.

(6) We endorse the requirement that HSA staff have expertise in financial and economic analysis.

(7) We urge inclusion of specific provisions for judicial review from decisions denying certificate of need.

(8) If the certificate of need process does not cover a particular class of provider, then resources acquired and controlled by those exempt providers should not be counted in the determination of institutional needs.

(9) We recommend flexibility in the proposed requirement that certificate of need decisions be consistent with the state health plan to assure that special needs of a local area take precedence over predetermined state goals.

(10) We endorse the exclusion of simple acquisition from the certificate of need process where they do not involve changes in beds or services.

(11) We oppose the proposed change in maximum review period for certificate of need application from 90 days to one year, but support a requirement the competing applications be considered at the same time.

(12) We urge that federal hospitals be required to comply with certificate of need laws.

(13) We support experimentation with voluntary decertification of unneeded facilities and services even though we believe potential cost savings from bed reductions have been grossly exaggerated.

(14) We recommend additional amendments to require HSAs to solicit competitive applications for needed services and facilities with selection of the most cost effective proposal, and exemptions for replacement of equipment.

Mr. ROGERS. Thank you for a concise and helpful statement.

Mr. PREYER.

Mr. PREYER. Thank you, Mr. Chairman.

I was, on a relatively minor point, I suppose, interested in Mr. McMahon's suggestion about Federal preemption of these multiple codes. I find hospitals in my area are continually upgrading through from local codes which have been more of a cost burden on them than any Federal regulations, I think. The idea of some uniform standards on that would seem to me to make a lot of sense.

I certainly appreciate your efforts to move more toward voluntary efforts and more flexibility in the local community. It is a question of trying to find the right sort of balance here, however. Everyone, I think, is in favor of controlling costs, but at the local level; as soon as you start restricting care in any way as a part of controlling costs, you stir up a political firestorm. So I think our standards have to be tough enough to put a little iron in the local community, or protect the local officials from too much political pressure if we want to get the job done on things like decertification. If a good-faith effort is made, and so forth, rather than, you know, saying "Do it."

I think it is a question of, will it work in a local community to rely on good-faith efforts?

Do you think they can withstand the political pressures in local communities if we make everything too voluntary?

Mr. McMAHON. Yes, I certainly do. We begin, as I noted in the testimony, to go in the other way. Suppose it is mandatory, suppose a health system agency of 30, 40, 50 people say this institution has to close or reduce the service or something else. All of a sudden, because of that line, you put the organized medical staff, the employees of the hospital, and the entire patient load in a solid position of opposition whereas, if things move along—it is true they will be slower—but if things move slower to figure out ways, when an institution or service is underutilized, there is some recognition that something has to be done; but the physicians have to have a place to practice, the employees need a place to work, and the patients have to have a place to go for care.

Our whole thrust is built on the principle that education about the utilization system, plus incentives to encourage activity, will bring about an atmosphere in which things move voluntarily whereas the confrontational situation is likely to solidify the status quo.

Mr. ROGERS. Will the gentleman yield at this point?

Mr. PREYER. Yes, of course.

Mr. ROGERS. Dr. Carter is going to have to leave and I would like him to question before he leaves.

Mr. CARTER. Thank you, Mr. Chairman.

You are very strong in your belief that hospital administrators should have a prominent part in the HSA's; is that correct?

Mr. McMAHON. Yes, sir.

Mr. CARTER. What percentage?

Mr. McMAHON. A minimum of one.

Mr. CARTER. One percent?



Mr. McMAHON. A minimum of one individual, that there should be at least one person from hospital administration or hospital management because the HSA needs to have somebody that can explain the whys and wherefores. That is why we have encouraged the inclusion of a manager or administrator. There may be a trustee or somebody that might be helpful in other areas, but they don't understand the administration.

Mr. CARTER. How many nurses?

Mr. McMAHON. I think that can be left to the local determination. I think because of the importance of the hospital——

Mr. CARTER. Do the nurses think that?

Mr. McMAHON. No; they do not.

Mr. CARTER. What about dentists, what about their representation, oral surgeons, particularly?

Mr. McMAHON. That is another problem. I would not mandate that because of the difference in the practice of dentistry, particularly in the smaller areas and trying to deal with that kind of issue in this context——

Mr. CARTER. Even in the smallest hospital we have to have some dentists to help us, practice ancillary surgery, and so on; and they feel deeply about it, too.

Mr. McMAHON. I am sure they do.

Mr. CARTER. What about insurers?

Mr. McMAHON. They should be consumers.

Mr. CARTER. All of these are consumers, are they not? Are you considered as a consumer at the present time?

Mr. McMAHON. No, sir, I would not be. I would be a provider.

Mr. CARTER. You are a provider, insurers are not considered as consumers, they are providers?

Mr. McMAHON. Yes.

Mr. CARTER. Everyone I have mentioned is a provider?

Mr. McMAHON. The insurance people ought to be consumers.

Mr. CARTER. You want to increase the percentage of insurers? Did you make that statement, Mr. Bromberg?

Mr. BROMBERG. I wanted to increase the number of public-elected officials as part of the present consumers.

Mr. CARTER. Will we diminish the number of hospital administrators, nurses, dentists, physicians, to accommodate the public officials?

Mr. BROMBERG. Let me make one point. The long list you gave us is a worthy list.

Mr. CARTER. I don't want a dissertation.

Mr. BROMBERG. The only component of the list you gave which is required to obtain a certificate to open, close, or purchase equipment is a hospital. For hospital management to be absent we think for that reason is a more obvious absence than any other profession.

Mr. CARTER. Public officials, what percent of either group should they compose?

Mr. BROMBERG. We would recommend up to 25 percent of consumers.

Mr. CARTER. Twenty-five percent of public officials. Again, would they be consumers or providers?

Mr. BROMBERG. It would seem to me most should be consumers.

Mr. CARTER. You are diminishing the real providers. They are getting less and less until you have no dentists, doctors, or nurses, or surgeons in your group. They will all be publicly elected officials and hospital administrators and other consumers.

Thank you, gentlemen. I have to go.

Mr. McMAHON. Could I add one comment for the record? This is a matter about which there is a great deal of confusion. My statement would go to some of the ways I think you might go. We spoke to the advisability of having hospital management because of the impact of certificate of need.

Obviously the committee has to look at other kinds of providers and consumers and we think that insurers, because of their interest, are more consumer oriented. I would say we have seen, as Mr. Preyer knows, and because of my own background, a strong predilection for involvement of State and local officials in this. The committee might want to consider a separate category of State and local government officials, rather than diminishing one group or the other.

We have not given it consideration but, in my personal opinion, I would not see any problem with setting up a separate governmental group. They are represented today and must be.

Mr. ROGERS. Mr. Preyer, go ahead.

Mr. PREYER. I don't have another question, but I want to thank you for your always useful suggestions and say that it seems to me the hospitals in my State have become much more cost conscious in the past few months. I think they have always done a pretty good job, but I give you gentlemen credit for making them take unusual measures lately and I hope that is going on all over the country.

Mr. BROMBERG. If I could add for the record, we should thank you, too, since you served on a commission that recommended that we take this effort.

Mr. ROGERS. Mr. Walgren.

Mr. WALGREN. Just briefly, I am so new in this that I don't know what the past job the hospitals have been doing, how good a job that has been. From Mr. Bromberg's statement it would seem that some of the excess cost that should be able to be squeezed out apparently does come from a lack of sufficient management personnel and when costs are not sufficiently reimbursed. Do you have a suggestion on how to get at that excess cost?

Mr. BROMBERG. We have now, I believe, for 11 years, appeared before the U.S. Congress and recommended that cost reimbursement under medicaid and medicare be phased out of existence. We continue to recommend it and some kind of target situation be established. We supported a bill cosponsored by Congressman Rogers and Senator Talmadge which would reward hospitals who come in below their peer-type hospitals and penalize those coming in above it.

We continue to recommend that just as we would continue to recommend, that insurance coverage be revised to treat outpatients and inpatients alike. We think a number of things like that could be done to turn the incentive around.

Congressman Preyer mentioned it before and Mr. McMahon did. We think the hospitals' managers need that little incentive to squeeze

some costs out. We don't think it is as much as the administration does. However, we think to reward that effort would be helpful.

Mr. McMAHON. In direct response to that I think the attention of hospital management is changing. The attention in the sixties was on ways to provide more and better care for patients—expansionist tendencies, if you like—and that was the key thing attention was focused on. Now there is a vastly different attention span because of the message from the payers of care, from business, from labor, from the public at large about the concern of hospital costs. That is why there have been in evidence in the last year or two a reduction in the rates of increases and why there is sympathy and support for the voluntary effort now going on, recognizing, as we testified before, that unlike a single yardstick applied to each institution, we need to accept the goal of the reduction in the rate of increase but tailor it institution by institution to what can be done in each institution, incentives in some cases but attention to the individual institutional problem which will work much better than an across-the-board yardstick.

A great advantage to the voluntary effort, like voluntary efforts I mentioned in response to the chairman's question about certificate-of-need, the encouragement and incentivizing of institutions will get the job done much better in a more fair and equitable way with better attention to patient care than an across-the-board yardstick.

Mr. WALGREN. I take it you target medicare and medicaid reimbursements to explain hospital cost escalation. Isn't the problem really that all medical costs are seen as insured expenses? And that the payment for these costs is not seen as a real expense because it is handled by a third party?

Mr. BROMBERG. Directly on point, Mr. Walgren, and we have said the reason why the Commission, the AMA's Commission on cost of medical care and in which Mr. Preyer made such a useful contribution, was to recognize and do something about the problem that exists, the problem of a rate of increase in health care costs and hospital costs that exceed the rise in the gross national product. We need a variety of measures. We need greater involvement in the economic dimensions of care by and the education of physicians. We need to strengthen physician review and audit. We need, on the institutional side, greater attention to efficiency as well as to the efficacy of procedures underway.

Finally, in many of the recommendations of that report we can see a need to alert the public to what its demands are doing to push up cost of care, and call for better attention to care of each individual by himself or herself. A better understanding of what to do when one is sick, injured or does not feel well is absolutely necessary to do something about the demand that itself is a part of the reason for increased costs and also inflation.

On educating the public not to ask for more and more. I am convinced the physicians are the key.

They order the tests, admit and discharge, and I believe the physician is most influenced by the patient. A lot of what the doctor does he might do differently if the patient incentives were different. If outpatients and inpatients were covered equally, the patient



would not ask to be in the hospital so it is all paid for. The patient would not reject office treatment if it was paid for, or at best 80 percent. We are all to blame, but it is the same Government and Cabinet officers we have today as 12 or 14 years ago when medicare passed. People were saying we want more access and more and better services. Now when the budget is in and it is tough, instead of changing the underlying program on cost reimbursement and insurance, they just want to put a cap on and keep it the way it is. The same problem is shared by all of us.

Mr. WALGREN. Thank you, Mr. Chairman.

Mr. ROGERS. I notice you say that the cost reimbursement system really provides no incentive for efficient management, Mr. Bromberg. What do you suggest?

Mr. BROMBERG. I would suggest immediate passage of the Talmadge-Rogers bill to correct it for at least the medicare and medicaid, which is about 40 to 50 percent of the business of most hospitals. I would suggest the voluntary effort and, if we ever consider national health, we abolish it from being used by private insurance companies.

Blue Cross has about 26 percent now of prospective rates, all different kinds. We feel the most likely to succeed are those under your bill and the Talmadge bill, hospitals of similar geographic areas, similar services, find the average cost of procedure and say, "That is the target rate. Those significantly above we won't pay." If a patient was going to a hospital like that, the patient should bear the additional cost.

Mr. ROGERS. I was pleased to see both organizations are supporting the extension of the bill. I notice you have some suggestions for change and making clear that guidelines are guidelines and not directives. I think this committee has pretty well gotten that commitment from the Secretary and the Department.

Mr. McMAHON. We hope you will look at the language change we have suggested to make sure that commitment is permanent and survives various incumbents.

Mr. ROGERS. We will look at that.

Also, the review procedures, you would consolidate requirements for review procedures, I believe, McMahon? That is on page 6, Pub. L. 93-641 requirements for review procedures in section 1532.

Mr. McMAHON. Yes.

Mr. ROGERS. You think that would be an essential?

Mr. McMAHON. Yes, we do.

Dr. GEHRIG. The proposed project should be acted on so a response is made and, if no response is made, the project should be approved in the 90-day period. There has been a suggestion that not saying anything means it is approved, this is totally unrealistic.

Mr. McMAHON. In our testimony we talked first about the recommendations for amendment to the existing law. We have not completely meshed those original studies we made with your new bill. We will be doing so and, as I requested in one specific area, we would like permission to submit further recommendations if we see ways we can tie some of these amendments directly to the changes you made.

Mr. ROGERS. Also, you might give us your ideas on the definition which you asked us to redefine of "indirect provider" serving on the board. What specific language or what intent would you have set forth in the definition of indirect provider?

Mr. McMAHON. We set that forth at the bottom of page 7 of the regular testimony. We have it in the attachment. I will ask Mr. Earle to direct himself to that question.

Mr. EARLE. Most of our proposals are technical in nature to try to clean up the definitions in the law. There are specific amendments, for example, there are those who under the current law would be classified as an indirect provider who should fall under the consumer category. We are attempting to clear that up. We are also recommending those people, the insurance people, be reclassified as consumers rather than on the indirect provider side. A few other amendments, like that to try to clarify this particular provision.

Mr. ROGERS. What about members of the immediate family?

Mr. EARLE. That is part of our definition?

Mr. ROGERS. I presume you would classify as providers people in the voluntary sector who are volunteers but, if they are professional people in the volunteer sector, how would you classify those?

Mr. EARLE. They would be providers. If it is less direct connection then they ought to be classified in the consumer category.

Mr. ROGERS. You think the Federal code should develop a single code and set of standards for physical requirements which would apply to all Federal programs and all State and local governments should be encouraged to adhere to this?

Mr. EARLE. Yes.

Mr. ROGERS. What are you thinking of starting with to simplify the code?

Mr. McMAHON. No, Mr. Chairman, we are starting with the problem of duplication and conflict. The situation that is brought to our attention over and over is where the local building code says one thing and OSHA says something different. It is the content of the code rather than the detail that causes the problem. We don't know where else to turn but to the Federal Government. We recognize that some States and localities will insist that peculiar problems of their own require special attention. We mentioned that in the testimony. We think we must start with a Federal set of standards, Federal involvement in the code and standards and regulations that are developed in order that we can avoid the conflict and focus in on that which is necessary rather than that which is desired, particularly in a cost containment era.

Mr. ROGERS. I notice you support uniform reporting. Do you support uniform accounting?

Mr. McMAHON. No, sir; and let me make clear for a minute that we think that accounting must have at the outset a management dimension. The real purpose of accounting is to enable managers to manage the institution. We have absolutely no problem with the desirability of uniform reporting and have worked out, as you recall, in connection with H.R. 3, we have worked out a modus vivendi with HEW on the way we are proceeding. We are in discussion



with them. The Planning Act has a little different provision than H.R. 3. We would like the two to be brought into agreement.

Mr. ROGERS. What assurance do we have the reporting reports will have similar and identical facts and figures unless we have uniform accounting?

Mr. McMAHON. HEW has proceeded to develop a mechanism by which that appears in the entries in the accounts of the institution set up to provide it with managerial information will go through a defined set of accounts into the reports. The thing is that this can be done periodically when a report is necessary rather than forcing the institution into a uniform accounting system which suits the purpose of the Federal Government but not necessarily the purposes of institutional management.

Mr. SAMSEL. The difference is in definition. As long as the amounts we are trying to account for are defined in the same way and going to the same account, there is no need to change the name of the particular account as long as it holds what we are looking for as a cost item. The problem of trying to set up a uniform chart of accounts for all managers everywhere means we all have to start speaking the same language, such as Florida, California, Washington, and so on, and we all have a different financial language. It works a great hardship on the financial manager if he has to change his system to agree with somebody else's. This is a national program and we believe the definition of what is included in an account is what is important, not necessarily the accounting system.

Mr. ROGERS. I believe most of the groups in your federation who own more than one hospital probably have uniform accounting within their system, do they not?

Mr. SAMSEL. We have uniform reporting, Mr. Chairman.

Mr. ROGERS. You don't have uniform accounting?

Mr. SAMSEL. Not necessarily. There is always a line—

Mr. ROGERS. Everyone I have asked before has told me that where they may have a hundred hospitals in their system—they have uniform accounting.

Mr. BROMBERG. Many have uniform accounting. Most have an internal uniform accounting system. What they call it is a uniform accounting system which is "management oriented" rather than cost oriented. They would need two accounting systems if Government had its way.

Mr. ROGERS. Maybe we would take the same one. If it is all the same verbiage.

Mr. SAMSEL. It would work in one system.

Mr. ROGERS. There has been a uniform accounting system recommended, has there not?

Mr. McMAHON. Yes; where the managerial requirements may be met.

Mr. ROGERS. I wanted to get that on the record, within your system you do it and you recommend it to your members.

Mr. SAMSEL. Again, those are guidelines.

Mr. ROGERS. I understand. We all know what guidelines are.

Mr. McMAHON. We thought we knew what guidelines were.

Dr. GEHRIG. In the discussion, and as we understand your bottom line, it is to obtain uniform reporting.

Mr. ROGERS. Just so we understand.

Dr. GEHRIG. The Department agrees that can be obtained without the straightjacket of uniform accounting.

Mr. BROMBERG. Since it is our membership that has the internal system, we don't recommend it to the members.

Mr. ROGERS. They already have it; that is correct.

Thank you for your testimony. It has been most helpful. We appreciate that. You have come in in a constructive way to help Congress in fashioning legislation that can be most helpful to the nation and its future health needs.

Thank you.

The next witnesses will be a panel of health maintenance organization representatives: Mr. James A. Lane, vice president of the Kaiser Foundation Health Plans, Inc., Kaiser Foundation Hospitals in California, accompanied by Dr. Frank Newman, vice president of the Kaiser Foundation Health Plans, Inc.; and Mr. Lewis J. Segadelli, executive director, Group Health Association, Inc., in Washington, D.C.

We welcome you gentlemen to the committee. Your statements will be made a part of the record in full, without objection, and you may proceed. It would be helpful to the committee if you could highlight the points you think the committee should direct its attention to.

**STATEMENTS OF JAMES A. LANE, VICE PRESIDENT AND COUNSEL, KAISER FOUNDATION HEALTH PLAN, INC., ACCOMPANIED BY H. FRANK NEWMAN, M.D., VICE PRESIDENT; AND LOUIS J. SEGADELLI, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION, INC.**

Mr. LANE. Thank you.

I am Jim Lane. I will address the impacts on HMO's and the serious problem it makes for HMO's in this area and there will continue to be problems unless it is amended.

The conflict is because there is conflict in the basic policy of the Government.

In 1972 the Federal Government through H.R. 1, section 1122 of that provision and through the Planning Act has embargoed on a course of restricting capital resource development. On the other hand, since 1973 the Federal Government through the Health Maintenance Act and amendments has encouraged the expansion and development of health maintenance organizations. Those two policies are in direct conflict because the Congress in both 1972 and 1974 chose to cover all activities of health maintenance organizations under the provisions of 1122 and the certificate-of-need requirements in the Planning Act, whereas it only covered some of the activities of other providers that do not operate on a prepaid basis. This policy is grossly discriminatory. It is discriminatory because ambulatory facilities and HMO's require certain approval while the same physicians and insurance companies do not. It is secondly discriminatory because, whether it is intended to do so or not, it perpetuates the status quo. Certificate-of-need laws are inherently

discriminatory against the new entrants, new organizations and especially discriminatory against the innovative organizations.

Now, I have searched through the records and through the evidence presented to the Congress as it was deliberating over the question of including or drafting certificate-of-need requirements and I have found no evidence that there are too many HMO's in the country, too much ambulatory HMO capacity or too many HMO hospitals. There is no need in this country to control the development of health maintenance organizations. Therefore, it is our conclusion that health maintenance organizations should not be covered by certificate-of-need requirements under this law.

The only basis put forward is the basis of the quality of treatment; that is, if you are going to cover fee for service hospitals, you should cover HMO hospitals. We think this, although apparently a fair analysis fails because of what has gone on in the last 3 or 4 years and I would like to give some examples. The basic problem is the planning process is so preoccupied with fee for service hospitals and providers it totally ignores HMO's. Last summer a State medical facility issued guidelines, a 277 page document directing States how to establish facilities under this act. There was not a single mention of HMO's. They were totally ignored. The national guidelines were issued in 1974, not a single mention of health maintenance organizations. On the local level I have been examining plans by the HSA's for critical review and it is extremely difficult to get them to mention HMO's.

In Los Angeles they didn't even bother to put in the language required by the Federal regulations and State law until we brought it to their attention.

So, on the outside it appears equal treatment is being provided but it is not in fact being provided. We think the only solution is to exclude all HMO's from the certificate-of-need requirements of this act and from section 1122 and, in addition, there is one other thing that needs to be done; that is, to prohibit States from covering HMO's in their acts.

What happened is that after the public law was passed the States started the process of requiring the certificate-of-need laws. We opposed the inclusion of HMO's in that law because we are working with Congress to try to change that.

In 1979 that issue was before the Congress and the Senate in the HMO amendments eliminated HMO's from the certificate-of-need requirement. This body did not. In Congress it was resolved by leaving HMO's in the act. At that time Chairman Rogers said that that matter would be resolved in 1977 when 93-641 was up for review. It was not because it was up for a simply 1-year extension. Nevertheless, he promised to examine the issue and treat HMO's and fee for service providers the same. That is what is attempted to do in this act. Nevertheless, since then many States, for only one reason, not because they felt it necessary to cover HMO's because they were compelled by the Federal Government to do so, have covered HMO's under their acts. Others are considering doing so in their sessions going right now. They don't want to do so in Oregon and Hawaii. They don't want to do so in Ohio, or in California. They will do so only if compelled.



Once in, however, it will be extremely difficult for those HMO coverage provisions to get out. They will be opposed by certain vested interests within the States. We think in some States we will be able to persuade State legislatures they should be removed, but we are fearful of what will happen where little HMOs' are just getting started and have no capability to affect State legislation in their area.

We think Congress has to address the issue and prohibit States from covering HMO's to the extent Congress decides they should not be covered under Federal law.

I suggest there will be considerable disagreement with our conclusion and would like to advise what you should do if you don't exclude HMO's. We concur in the provision that HMO ambulatory provisions should not be covered. There is considerable criteria covered when you examine the application. The need should be based on the existing or reasonable anticipation of new members of HMO's. That way the HMO's can plan for growth and development. This should be particularly true in ambulatory care and equipment, and in modernization and remodeling.

One of our biggest concerns is we will be prevented from keeping our facilities from being modernized, somebody will decide we should be prevented from spending our money to modernize our facilities. If hospitals of HMO's are to be covered, there is a serious problem. The reason usually given is HMO's should be able to use hospital facilities in the rest of the community. That is sometimes the case.

In Colorado we do use a community hospital. It has been very successful in its organization. That is not always the case. You can't always find the beds, you can't always find physicians associated with HMO's and admitted to the staff. You can't always find financial arrangements are adequate.

On page 7 we proposed some criteria to be used in determining whether HMO's can get hospital service in the communities or not. We feel if HMO's can't get hospital service in a community based on this criteria it should be allowed to construct its own hospitals.

Two other points. We feel that the health systems plan and the State health plan and the State medical facilities plan should be required specifically to deal with the development of HMO expansion. The States in the HSA should be required to deal with and address the question of how many and how much HMO capacity there should be.

The second issue, section 1527—this is not in my statement because I didn't have the bill at the time I prepared it—section 1527 (a)(6) provides certificate-of-need decisions should be consistent with the health systems plan. That sounds fair.

The problem is that most health system plans won't address many of the projects for health nor certificates of need. For example, medical office buildings, the plans I have examined don't have any criteria for determining whether a medical office building in an HMO is needed, parking lots, clinical labs, leading of computers. We had to get a certificate of need to get a computer in California. Leasing

space, as we rent an office building for our health plan officers, we have to lease it. None of the plans has dealt with those issues.

We recommend you provide not that the application must be consistent with the plan but that it not be inconsistent with the plan, a substantial difference. If the plan is silent on the subject, you do not need to show consistency with it.

In conclusion, as I indicated before, there is a substantial conflict in Federal policy between resource control and between HMO expansion. We think that the conflict right now is in the direction of very seriously hampering HMO development in this country and, therefore, we strongly recommend it be resolved in favor of HMO development.

We will submit very soon proposed amendments which will accomplish this objective.

[Testimony resumes on p. 1037.]

[Mr. Lane's prepared statement and attachment follow:]



Statement Before the Subcommittee on Health and the Environment  
of the Committee on Interstate and Foreign Commerce  
United States House of Representatives

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Submitted by Kaiser Foundation Health Plan, Inc.

February 2, 1978

Mr. Chairman and Members of the Committee, I am James A. Lane,  
Vice President and Counsel of Kaiser Foundation Health Plan.

The Kaiser-Permanente Medical Care Program

The Kaiser-Permanente Medical Care Program is comprised of Kaiser Foundation Health Plan, a nonprofit corporation, Kaiser Foundation Hospitals, a charitable and nonprofit corporation, and six independent Permanente Medical Groups. It is an economically self-sustaining health care system that provides prepaid health care services to more than 3.3 million members in California, Oregon, Washington, Hawaii, Ohio and Colorado. It is a systematically planned and organized approach to the provision of health care that arranges direct health care services for its members in 26 acute general hospitals and 72 outpatient facilities. The Program employs more than 28,000 non-physician personnel. Professional services are provided by more than 3,300 physicians associated with the independent Permanente Medical Groups.

The Kaiser-Permanente Program is the largest group practice prepayment program in the United States. It has succeeded and grown in the face of healthy competition from commercial health insurance, Blue Cross, Blue Shield, self-insured programs, and other HMOs,

despite the opposition of some segments of organized medicine. The Program has pioneered many features, such as comprehensive prepaid services, including prevention and early detection of disease, quality assurance based on peer review, and effective cost control, particularly with regard to expensive hospital services, that Congress has sought to encourage and expand.

Congress intended to encourage development and expansion of group practice prepayment programs when it enacted the Health Maintenance Act of 1973 and the HMO Amendments of 1976. This occurred because such organized health care systems have demonstrated their ability to provide a comprehensive range of prepaid health services to their members at a reasonable cost. They are at the forefront of innovation in health care delivery and have led in providing preventive health services and using health care resources efficiently. Furthermore, the success of group practice prepayment programs has resulted in innovative responses from traditional health care providers, such as development of Foundations for Medical Care and expansion of the prepaid benefits offered by competing health benefits carriers.

#### HMOs and P. L. 93-641

Therefore, it is ironic that as far as health maintenance organizations are concerned, P. L. 93-641 could be called the Anti-HMO Act of 1974. This is because the Act's required certificate of need program discriminates against and creates serious problems for HMOs in two ways.

First, HMOs are required to obtain certificates of need for their ambulatory and administrative facilities and equipment while fee-for-service providers are not.

Second, HMO hospitals (hospitals that provide 75 percent or more of their services to HMO members) are covered in the same manner as fee-for-service hospitals. Although this may appear to be a neutral posture toward HMOs, it is, in fact, discriminatory. Certificate of need laws perpetuate the status quo. They protect existing facilities from competition without regard to the need for such facilities, their quality or their cost effectiveness. Discrimination also occurs due to the bias against HMOs of some providers who serve on Health Systems Agency (HSA) boards.

Congress was concerned about this bias and the Act requires State Agencies and HSAs to consider the special needs and circumstances of HMOs for which assistance may be provided under title XIII of the Public Health Service Act (§1532(c)(8)). However, the Department of Health, Education and Welfare has failed to adopt adequate regulations to implement this provision despite clear instructions to do so in the Conference Report on the HMO Amendments of 1976 (pp. 36-37).

Therefore, we have concluded that the most appropriate action to insure that certificate of need programs do not impede development and expansion of HMOs is to exclude HMOs and their facilities, including their hospitals, from required certificate of need programs.

The exclusion also should provide that a state health facilities

planning program may not be approved by HEW if it requires certificates of need for HMOs or their facilities. This is necessary because some states have already included HMOs in their certificate of need programs pursuant to the requirements of P. L. 93-641, and it may be difficult to exclude HMOs from certificate of need laws in some states due to the opposition of those special interests which want to control or stop HMO development.

HMOs and their facilities should be excluded because:

1) There is no reason to impose external constraints upon the development of HMO resources. Unlike the fee-for-service system which certificate of need programs are designed to regulate, HMOs have inherent incentives which result in appropriate development of resources to meet the needs of existing members and reasonably anticipated new members. HMOs have no incentives to have unnecessary facilities or to provide unnecessary services.

2) Mature HMOs have demonstrated their capability to plan appropriately and new HMOs have shown that this capability can be replicated.

3) Hospital-based HMOs have grown at a rapid rate and should be encouraged to continue that growth without changing their essential method of operation. They should not be required to attempt to use unacceptable, inefficient or otherwise undesirable excess resources in the area. Although conceptually attractive, the use of such resources can fragment and distort an HMO's delivery system and can impair

the quality and availability of services to the members of HMOs.

HMOs have not been responsible for developing excess resources.

They should not be required to use inappropriate facilities and increase the costs for their members.

4) The certificate of need process can cause unreasonable delays and exhaust valuable managerial resources. Even though a certificate of need is granted, it may be after a substantial struggle and considerable delay. This is especially true where there is strong anti-HMO bias.

5) Hospital-based HMOs combine appropriate hospital utilization with increased physician efficiency and thus have lower total costs than non-hospital based HMOs. Being hospital based enables an HMO to develop needed resources in more appropriate ways. This model should be encouraged, not artificially constrained by certificate of need laws.

6) If an HMO is required to use excess resources in an area, there is no guarantee that they will be available to HMO members as long as they need them. One concern is that hospital based HMOs will be denied permission to build based upon a short-term bed surplus which will disappear because of population growth or an aging population. The resulting shortage of beds will mean that the bed needs of the HMO's members can no longer be met and it will have no alternative resources available and will not be able to construct necessary beds within a time frame that will meet the needs of its members.



7) If a hospital-based HMO is allowed to develop its own hospital in an area where there are excess hospital beds, the cost to the total community will be lower in the long run than if the HMO is not allowed to expand. (See Exhibit I.)

We strongly support the exclusion of HMO hospitals from certificate of need requirements, but the Committee may feel differently; if so, we suggest the following guidelines in making decisions concerning HMOs and certificate of need programs:

1) HMO facilities, and equipment should not be covered unless fee-for-service facilities and equipment are covered. To do otherwise is discriminatory.

2) States should not be permitted to include any HMO facilities and equipment which are excluded from Federal certificate of need requirements. Otherwise, because many states have already included HMOs, elimination of the federal requirement may have no effect.

3) The public interest in fostering development of effective organized health care delivery systems requires that projects for HMO facilities and equipment should be judged on the needs of existing and reasonably anticipated new members of the HMO, not on the needs of the community in general. This is especially important for the modernization and replacement of existing HMO hospitals and other facilities. An HMO should not be denied approval to maintain or modernize its hospitals and other facilities simply because there are excess hospital facilities in the area. To do so, would result in disruption of existing

services to HMO members and fragmentation of effective health delivery systems.

4) If HMO hospitals are covered, an HMO should be allowed to build its own hospital unless the State Agency determines that hospital services are available to HMO members in a cost-effective manner which is consistent with the basic method of operation of the HMO. In making such a determination, the State Agency should be required to find that:

, (a) The services are available in one hospital;

(b) The services are available on a long-term contractual basis commensurate with other long-term commitments of the HMO or five years, whichever is longer;

(c) Qualified physicians associated with the HMO will be granted full staff privileges at the hospital; and

(d) The services are available in a manner which is economically and clinically feasible for the HMO.

Anything less than this in the Act will leave HMOs at the mercy of regulation writers and the interpretations and biases of HSAs and State Agencies and will continue the discriminatory aspects of P.L. 93-641.

We recommend two additional changes. First, HSAs and State Agencies should be required to prepare specific plans for HMO development and expansion. Each health system plan and state health plan should contain an HMO element which describes existing HMOs, their membership, facilities and services and their plans for expansion. It should be the goal of each HSA and State Agency to develop enough HMO

capacity so that all persons in the area will have the option to voluntarily join an HMO. Otherwise the objectives of the HMO Act of 1973 can be subverted.

Second, §1513(e) should be amended so that HSAs are limited to review and comment authority over grants, contracts, loans and loan guarantees under the HMO Act, rather than review and approval authority. The implementation of the HMO Act has a high national priority. HSAs should not be permitted to thwart this priority by disapproving HMO development or expansion projects which HEW determines are in the national interest.

These changes P. L. 93-641 are essential to development of new HMOs and rapid expansion of existing HMOs. This is a stated goal of Congress and the Administration. It should not be frustrated by a planning act which is designed to impose rationality upon the fee-for-service delivery system. HMOs already plan rationally because they have internal incentives to do so.

Sound public policy requires that regulatory systems be carefully designed to address specific problems. They should not be applied to organizations which are not creating the problem or in a manner which inhibits organizations which have great potential to assist in solving the problem. Therefore, we conclude that the soundest approach is to exclude HMOs and their facilities and equipment from certificate of need programs and not permit states to cover them.

EXHIBIT 1

# SELECTED USE OF COMPETITION BY HEALTH SYSTEMS AGENCIES

## FINAL REPORT

Submitted to:

Bureau of Health Planning and Resources Development  
of Health Resources Administration, DHEW  
Contract No. HEW-HRA-230-75-0071

December 1976



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This is especially the case where competition from HMOs and other health plans ensures that individual HMOs maintain close control over their expenditures. The possible exceptions would be where HMO competition does not exist or where external subsidies offset the effect of such expenditures on premiums. However, in general, there is little evidence that there is anything to be saved by implementing controls over HMO outpatient facility construction and equipment purchases, especially in light of the cost of implementing these controls and the risk of limiting the long-term useful effects of HMO competition.

c. HMO Hospital Construction. We found that several large HMOs have sought to build or purchase their own hospitals when their enrollments reached high levels. Hospital ownership appears to produce significant savings over the continued use of non-HMO facilities and allows HMOs to improve the quality of inpatient care to their members. In addition, hospital ownership ensures that beds are available when needed, that HMO physicians can obtain staff privileges and that HMOs do not indirectly subsidize other health plans. In order to evaluate the desirability of HMO construction of hospitals, we estimate the impact of HMO hospital construction on community costs. We assumed that an HMO's acquisition of its own hospital produced net savings from all sources of 10 percent in average HMO costs. Although there is little evidence on the actual savings available from HMO hospital ownership alone, HMO administrators indicate that a ten percent savings seems attainable. This savings is consistent with the HMO cost comparisons cited in Chapter III. Using this assumption and our HMO cost model, we examined the annual community costs (savings) per



member under two cases: the first, where community beds are not needed; the second, where they are needed. In addition, we examined the impact of alternative HMO enrollments over the likely range of values where hospital construction might be effective. Table II-9 summarizes these results.

Table II-9

Annual Community Costs (Savings) Per Member (In Dollars)  
Under Alternative Enrollments (In Thousands)

<u>Alternative Bed Requirements</u>	<u>60</u>	<u>80</u>	<u>100</u>	<u>120</u>
<u>No Community Beds Needed</u>				
Group Practice HMO (Base Case)	(\$21.17)	(\$24.25)	(\$26.10)	(\$27.33)
Group Practice with New Hospital	(\$ .17)	(\$ 3.25)	(\$ 5.10)	(\$ 6.33)
<u>Community Beds Needed</u>				
Group Practice HMO (Base Case)	(\$53.27)	(\$56.35)	(\$58.20)	(\$59.43)
Group Practice with New Hospital	(\$59.77)	(\$62.85)	(\$64.70)	(\$65.93)

We found that where community beds are needed, HMO development and HMO hospital construction both produce substantial savings. HMO hospital ownership clearly enhances the savings made possible by encouraging HMO development. Where beds are not needed, HMO hospital ownership still produces community savings, but is less attractive than the continued use of existing hospitals. The best alternative in this situation is the purchase of an existing hospital by the HMO. Specifically, our analysis suggests that:

- where additional community beds are needed, community costs can be reduced the most by permitting an HMO to purchase or build its own hospital facilities; HMOs can reduce community costs as long as hospital ownership permits HMOs to reduce their hospitalization costs;
- where additional community beds are not needed, community costs can be reduced the most by requiring an HMO to acquire an existing community hospital in lieu of building a new one, if an appropriate existing hospital is available at a reasonable price;
- when existing community hospitals are not suited to HMO needs or unwilling to sell at a reasonable price, community costs are reduced the most by delaying all new construction until additional beds are needed in the area and by giving the HMO first priority on construction when need appears. However, if the HMO, as a result of such delay, is likely to lose enrollment or otherwise not expand its enrollment, then community costs are reduced the most by permitting the HMO to build. In addition, reducing the need for fee-for-service beds by appropriate amounts enhances the savings still further; and,
- where new beds are needed within the next 3-5 years (the lead time for construction of a new hospital), where the HMO has an enrollment in excess of 80 thousand members, and where the HMO has demonstrated an inability to purchase an existing facility under reasonable terms, community costs are reduced the most in the long run by permitting the HMO to build new beds. Community savings in the short run are sufficient to justify the construction of the hospital prior to an explicit need for more community beds.

We did not examine these factors for networks and IPAs because their enrollments typically have not been high enough to justify hospital construction. However, this characteristic may change in the future and may warrant closer examination.

d. Recommendations. Based upon our findings above, we developed recommendations affecting health planners' major activities, including health plan development, project review and health plan implementation. Our findings strongly indicate that HMO development is consistent with the long run health planning priority of cost control even though there may be

a slight increase in costs in the short run. In addition, we could find no basis for concluding that HMOs achieve these reduction at the expense of quality. HSAs concerned about the possibility of lower quality can better address this concern by ensuring that consumers are informed about publicly available measures of quality rather than preventing HMO development. Generally, we recommend that health systems agencies:

- promote HMO development by allowing unrestricted entry of HMOs, encouraging potential sponsors, and eliminating local conditions that inhibit HMO entry; financially viable HMOs will generally reduce long run community costs, and past experience shows that HMOs that are not viable close without adverse impact upon HMO enrollees. Active competition among HMOs appears also to decrease community costs. Hence, HSAs should give a high priority to competitive HMO development in areas where significant community cost savings can be achieved. Such areas can be identified by using local cost and utilization characteristics and expected HMO enrollment projections with the community cost-estimating methodology presented here. The most important point here is for HSAs to understand that HMOs, unlike hospitals, can reduce community costs in the long run even though there is some duplication of investment in the short run.
- address the potential problem of poor quality or accessibility which could result from unrestricted entry by emphasizing the public disclosure of information on HMO utilization rates, accessibility, and patient satisfaction; establishing and enforcing quality standards for HMOs is the primary responsibility of state licensing authorities, PSROs, state Medicaid agencies, and DHEW, in the case of federally assisted or qualified HMOs. More importantly, HMOs competing in the private group market are continually subject to scrutiny by prospective consumers. Hence, HSAs should adopt a quality assurance role that supplements rather than duplicates the activities of these bodies. HSAs can do so by cooperating with these organizations and consumer groups to make information that is collected on HMOs more readily available to the public in an understandable form. Because HMO quality is difficult to predict prior to operation and difficult to observe and interpret subsequent to operation, this communications role for HSAs effectively complements existing quality controls.

In developing local area health plans, HSAs should include explicit provisions regarding HMO growth and development. Specifically, HSAs should:

- establish an explicit need for HMOs in all areas where HMOs are likely to reduce community health care costs, using the methodology developed here. Even where community costs may not fall, a need for HMO development should be established where less than 80 percent of the local population has an option to join an HMO. This definition ensures that, in areas where HMO development can reduce community costs, HSAs establish a clear need for HMOs even if over 80 percent of the population already has the option to join them. This approach encourages competitive HMO entries so that community savings are generated beyond the savings a single HMO could produce. In addition, in areas where community costs might not fall, the importance of making the choice of greater accessibility to primary care available is the primary concern. Although HMO operations may not be feasible in these areas, this definition ensures that sponsor interest or federal support is not discouraged or precluded on the grounds that community costs are not likely to fall.
- establish an explicit need for both community and HMO beds which reflect expected HMO growth and development. HSAs should establish explicit measures of community and HMO bed need so that bed need projections reflect the impact of lower hospital utilization rates of HMO members, and so that future requirements for hospital facilities by large HMOs are anticipated. By forecasting bed need in this way, HSAs can avoid the construction of too many community hospital beds and ensure that HMOs growing toward 80-100 thousand members can anticipate HSA reactions when they want to acquire their own hospital. This in turn enhances the community cost impact of HMO development by reducing the costs of supporting underutilized hospitals.

In project reviews of HMO requests for approval of new institutional health services (NIHS) and certificates-of-need, HSA criteria should reflect our findings about the ability of HMOs to reduce community cost. Specifically, HSAs should:

- permit all HMOs to enter the local market or add new services, because financially viable HMOs will generally reduce community costs in the long run. HMOs unable to control costs or enroll enough members to break-even will typically not reduce community costs. However, they are likely to go out of business and consequently pose little risk of raising long run costs due to a duplication of resources. Even if HSAs wish to restrict HMO entry, they should approve HMOs that are likely to reduce com-

munity health care costs in areas where the local health plan identifies a need for HMOs. HSA should also permit new HMOs to enter and compete with existing HMOs because active competition among HMOs generally increases community cost savings.

- approve all construction of outpatient facilities or purchase of new equipment by existing HMOs; HMOs, unlike hospitals, have no incentive to invest in facilities or equipment unless these purchases reduce long run costs of operation, or maintain or increase enrollment by improving the quality or accessibility of care. In some cases, outpatient or equipment expenditures might diminish the overall community cost savings available from HMO operation. However, in such cases, the community cost impact of these expenditures is relatively small. Finally, HSAs may be able to strengthen incentives for reducing community costs in the long run by giving HMO investments in outpatient facilities and equipment higher priority than traditional provider investments. Traditional providers facing such review criteria might consider HMO development opportunities more carefully under these incentives.
- approve all HMO requests to purchase, lease or otherwise acquire existing community hospitals regardless of the number of beds available or needed by the community; in all cases, HMO use of existing hospital facilities produces the greatest community cost savings. HSAs and SHPDAs can give large HMOs an added incentive to pursue this alternative by adopting policies to approve all such acquisitions. Some caution should be exercised where HMOs with fewer than 80-100 thousand members seek to acquire hospitals; however, HMO administrators advise us that this is most improbable.
- approve all HMO requests to construct hospitals where there is or will be shortly (3-5 years) a need for additional or modernized hospital beds; our analysis shows that community costs are reduced the most where HMOs can operate their own hospitals. Although HMO purchase or lease of existing hospitals is always desirable, it is possible that existing community hospitals are not well-suited to HMO operations because they are not located near HMO members, would require excessively expensive modernization, or are not available at a reasonable price. Thus, although HMOs have an incentive to purchase or lease rather than build if it is less expensive, they may not be successful in securing reasonable terms. In such circumstances, community costs are reduced the most where HMOs are permitted to build hospitals. In fact, HMO construction of needed beds reduces community costs more significantly than traditional provider construction of new beds.



- approve HMO requests to build a hospital in areas without any need for additional beds, when:

- an HMO's ability to reduce community costs is severely hampered by use of existing community hospitals; and,
- the HMO can show that existing hospitals are not suitable or not available at reasonable terms for sale or lease.

Our analysis of the community cost impact of hospital construction by an HMO showed that community cost savings are still obtained, even if an HMO builds its own hospital in an area with too many community hospital beds. Hence, HSAs should permit HMOs to build their own hospitals where the continued use of existing community hospitals threatens the HMO's financial viability or the maintenance of its current enrollment. This produces more significant community savings than letting the HMO fail, especially over the expected life of the hospital.

These recommendations are based upon a careful analysis of the community cost effects of HMO growth and development. Because the results vary from region to region and because BHPRD may want to extend the use of the methodology developed here, we recommend that BHPRD review and refine the models developed here to confirm their soundness and suitability. Particular attention should focus on:

- the verification and refinement of the community cost-estimating methodology presented here;
- the differential effect of federally qualified HMOs on community costs;
- the effects of HMO competition on premiums, community costs, and quality; and,
- the problems that face members of HMOs that close due to financial failure.

A careful review of these factors could greatly expand the applicability of the basic analysis presented here.

Mr. PREYER [presiding]. Thank you, Mr. Lane.  
Mr. Segadelli has a statement, I believe [see p. 1040].

### STATEMENT OF LOUIS J. SEGADELLI

Mr. SEGADELLI. I have submitted a statement and will not read from it. I would like to highlight two aspects of our experience which supports what Mr. Lane said.

GHA strongly concurs and endorses his comment. GHA takes care of 108,000 people in the metropolitan area of Washington, D.C. About 50,000 of them are residents of the District of Columbia, and about 30,000 are residents of Prince Georges and Montgomery Counties in Maryland and about 12,000 or 13,000 are residents of Fairfax County and Virginia. That is the basis of one of our problems and probably of HMOs' in the planning process.

We had recent experience in Prince Georges County involving an ambulatory facility. In that quadrant of the Washington area we have about 31,000 people, 11,000 or 12,000 living on the Maryland side and 20,000 on the District side. We proposed to put an ambulatory facility in Marlow Heights, 2 or 3 miles outside the District. We went into the situation relatively naively and discovered belatedly that we were in a different fight, one which involved four separate meetings of the HSA and its committees.

Some of the opposition was very predictable. The medical society opposed us, the hospitals opposed us. You could attribute that to competition. One of the bases of opposition was a surprise. We lost a number of votes from the HSA and finally won by a vote of only 13 to 12 with a number of people abstaining on the building of a facility because we would not guarantee to hospitalize Prince Georges County residents, members of GHA in Prince Georges hospitals.

We were asked to distort our entire structure to meet local community needs. An institution which, in terms of the metropolitan area is regional, having to deal across at least four political subdivisions is at a very distinct disadvantage in trying to push forward its planning and meet its organizational needs against local interests which can mobilize very strongly in a given local area. I think this is an argument that adds to the need to exempt HMO's in the planning process if you are going to press the HMO concept.

The second experience involves our proposal to have a hospital in the District of Columbia. At about 108,000 or 110,000 members, an HMO seriously can begin to think about its own hospital and I think the statements by Mr. Lane and others will indicate that HMO's which have their own integrated system of inpatient-outpatient care—hospital plus ambulatory facilities—can provide a much more cost effective medical care delivery. We proposed to build a 180 bed hospital on Wisconsin Avenue and we filed an application about 2½ years ago. We won at least the neutrality of the local residents in their neighborhood advisory council and a fair number supported us and then we went to the planning agency then existing in the District, which is the State in this instance, and lost the effort in spite of the fact that the laws then on the books and still on the

books provide for special consideration for HMO's and preference for HMO needs. I have to say that, in our experience, these considerations were ignored, these and the first application was turned down strictly on the basis of the fact that the District was over-bedded. The District has been over-bedded for 3 or 4 years, probably a thousand beds more than the District needs, which is 20 percent of the bed complement.

That is also true of the suburbs and, if one says to HMO's in any area where there are more beds than are needed, you cannot build more beds than needed in the plan, an HMO or anybody else with an innovative plan that might come along in the future will be stymied. We are franchising hospitals just because they are there. We are saying that the present structure cannot be disturbed until such time as the number of beds comes into consonance with the plan. That will prohibit the development of HMO's.

We have, since the first application was turned down, come up with a very innovative idea. It will be interesting to see how that is met.

There is in the District of Columbia the Washington Hospital Center, a 900-bed hospital complex in about the center of the city in the central east, more or less. The Washington Hospital Center offered to us land on its campus site, approximately  $2\frac{1}{2}$  acres, on which GHA could build a 150-bed hospital. The rent would be nominal and the Washington Hospital Center has already done this kind of thing before. It had already brought to its campus the Children's Hospital, that now operates there.

In addition to that they have offered to give up 80 of their current beds to us if the city gives us the certificate to build. In exchange for this concession, we would agree to buy from the Washington Hospital Center what is called tertiary care, the more complicated medical care that is sometimes needed, in contrast to the greater number of confinements which only involve routine care. We would probably do our obstetrics in the Washington Hospital Center's obstetrics unit, which would lower the cost to us and to them and make the delivery much more efficient. We would continue to care for our children in the Children's Hospital right on the campus grounds. All of this would account for about 20 percent of our bed needs.

The remaining 80 percent, which are the more routine kinds of hospital care, we would provide in our own hospital—on their grounds. In addition to that, we would buy our utilities from them—that kind of service. So we think this is a very cost effective proposition, for both parties.

What we are pleading for is that, if we get turned down, if we have to go through the grinder of planning agencies and lose, that we have some recourse, some way to go. The last time around we met the unified opposition of all the existing hospitals in the District. We don't know what is going to happen the next time around, but we do know that we have been delayed 3 or more years and the cost of providing our own hospital has gone up 30 or 40 percent as a result of inflation alone and we are not able to provide the kind of cost effective efficiencies we think we ought to be able to offer.

Therefore, we join with the Kaiser organization in urging the exemption of HMOs from the Planning Act because we think we can do the job better for our own enrollees, while providing a competitive yardstick for other health providers in the greater Washington area.

Thank you, Mr. Chairman.

[Testimony resumes on p. 1046.]

[Mr. Segadelli's prepared statement follows:]

## STATEMENT BY

LOUIS J. SEGADELLI, EXECUTIVE DIRECTOR

GROUP HEALTH ASSOCIATION, INC.

WASHINGTON, D. C.

GOOD MORNING, MR. CHAIRMAN. I AM LOUIS J. SEGADELLI, EXECUTIVE DIRECTOR OF GROUP HEALTH ASSOCIATION OF WASHINGTON, D. C. IT IS A PRIVILEGE TO APPEAR BEFORE YOU AND DISCUSS SOME SPECIFIC PROBLEMS RAISED FOR GROUP HEALTH BY THE U. S. HEALTH PLANNING & RESOURCE DEVELOPMENT ACT OF 1974.

GROUP HEALTH ASSOCIATION, OR GHA, AS IT IS USUALLY CALLED, IS IN ITS 41ST YEAR OF SERVICE AS A HEALTH MAINTENANCE ORGANIZATION (HMO). IT IS A 40 MILLION DOLLAR BUSINESS THAT NOW SERVES MORE THAN 108,000 WASHINGTON AREA RESIDENTS, PRIMARILY THROUGH ITS FOUR (SOON TO BE FIVE) MEDICAL CENTERS. GHA IS A MEMBER OWNED, FEDERALLY QUALIFIED, NON PROFIT HMO.

WE ARE HERE TO URGE THAT THE PLANNING ACT BE AMENDED TO ALLOW HMO'S LIKE GHA TO PLAN AND BUILD THEIR OWN HOSPITALS AND HEALTH CENTERS FOR THEIR OWN ENROLLED POPULATIONS, WITHOUT HAVING TO APPLY TO THE LOCAL HEALTH SYSTEMS AGENCIES FOR CERTIFICATES OF APPROVAL TO PROCEED WITH SUCH CONSTRUCTION, AS REQUIRED BY THE HEALTH PLANNING ACT. THE LENGTH OF CERTIFICATE OF NEED REVIEWS HAVE PROVEN VERY COSTLY TO GHA AND OTHER HMO'S. OUR FIVE YEAR HOSPITAL PLAN HAS BEEN ABORTED AND OUR HEALTH CENTER DEVELOPMENT RETARDED BY THIS REQUIREMENT.

COMMON ECONOMIC SENSE KEEPS HMO'S FROM BUILDING MORE OR LARGER FACILITIES THAN THEY NEED. SINCE HMO'S SERVE ONLY THEIR ENROLLED, PREPAID MEMBERS, IT IS AGAINST THEIR FINANCIAL INTEREST TO BUILD EITHER A HOSPITAL OR HEALTH CENTER LARGER THAN THEIR CURRENT ENROLLMENT AND THEIR GROWTH PLAN INDICATES IS ECONOMICALLY



SOUND. GHA'S EFFICIENCY AND ITS ABILITY TO CONTROL COSTS ARE TIED DIRECTLY TO MAXIMUM CONTROL AND OPERATION OF ITS OWN HEALTH CARE DELIVERY SYSTEM, PARTICULARLY AS TO ITS OWN HOSPITAL, BUT ALSO AS TO OPERATING ITS OWN HEALTH CENTERS AND USING A FULL TIME MEDICAL STAFF.

OUR MUCH LOWER HOSPITAL UTILIZATION RATES WOULD ENSURE LOWER OVERALL HEALTH CARE COSTS TO THE CONSUMER IF WE OWNED OUR OWN HOSPITAL. WE ARE NOW AT THE MERCY OF GENERAL AREA HOSPITALS AND THEIR CHARGES. THIS COST ALONE AMOUNTS TO MORE THAN ONE-THIRD OF OUR OPERATING COSTS. DOCUMENTATION HAS BEEN SUBMITTED TO THIS COMMITTEE WHICH SHOWS THAT HMO'S WHICH OWN OR OPERATE THEIR OWN HOSPITAL(S) ARE, ALMOST WITHOUT EXCEPTION, MORE COST EFFECTIVE THAN HMO'S THAT DEPEND UPON COMMUNITY HOSPITALS FOR BEDS.

GHA'S FIRST APPLICATION TO THE WASHINGTON, D. C., DEPARTMENT OF HUMAN RESOURCES FOR A CERTIFICATE OF NEED TO BUILD ITS OWN HOSPITAL HERE IN THE DISTRICT WAS BEFORE THE DHR FOR NEARLY TWO YEARS BEFORE BEING REJECTED, BASED ON BED NUMBERS ALONE. THERE WERE OTHER FACTORS IN THE PROPOSAL WHICH AFFECTED THIS JUDGMENT, INVOLVING DOCTORS HOSPITAL, WHICH RECEIVED A GOOD DEAL OF PUBLICITY, BUT NEED NOT BE REPEATED HERE.

WE NOW HAVE A SECOND APPLICATION IN THE DISTRICT, JOINTLY SPONSORED BY THE WASHINGTON HOSPITAL CENTER, A 900 BED GENERAL HOSPITAL COMPLEX IN THE DISTRICT. WE ARE WELL AWARE THAT MORE THAN 1,000 BEDS HAVE BEEN VACANT EVERY DAY FOR NEARLY 3 YEARS IN THE DISTRICT OF COLUMBIA, ACCORDING TO THE AMERICAN HOSPITAL ASSOCIATION. THIS REPRESENTS ABOUT 20% OF THE AVAILABLE BEDS.

THE AHA ALSO REPORTS THAT 20% OF THE BEDS IN THE WASHINGTON SUB-URBS ALSO HAVE BEEN VACANT EVERY DAY. EVERY JURISDICTION IN THIS AREA IS OVER-BEDDED. WHAT IS GHA TO DO? IS IT ENOUGH, AS SOME SAY, TO CRY "STOP - NO MORE BEDS FOR ANY REASON"? OR, DOES RESPONSIBILITY TO CONTROL THE NUMBER OF BEDS ALSO CARRY WITH IT RESPONSIBILITY TO SEE TO IT THAT EXISTING BEDS ARE WISELY USED AND MEET ACTUAL NEEDS? ARE WE GOING TO GIVE A PERMANENT FRANCHISE TO AN INSTITUTION JUST BECAUSE IT IS THEIR? FOLLOWING THE PRESENTATION BY GHA TO THE ADVISORY COMMITTEE TO D.C.'S HEALTH PLANNING AGENCY, RELATING TO OUR APPLICATION FOR A CERTIFICATE OF NEED TO BUILD A GHA HOSPITAL, A NUMBER OF THE MEMBERS OF THE COMMITTEE EXPRESSED THE VIEW THAT THEY HAD TO REJECT GHA'S APPLICATION, ALTHOUGH IT HAD MERIT, BECAUSE THEY WERE LIMITED TO DETERMINING ALLOWABLE NUMBERS OF BEDS. THEY HAD TO IGNORE WHAT SOME OF THEM KNEW - THAT ON THE WEST COAST, HMO'S (THE KAISER FOUNDATION HEALTH PLAN AND THE GROUP HEALTH COOPERATIVE OF PUGET SOUND) HAVE DEMONSTRATED THAT ONLY 2 BEDS PER THOUSAND ARE NEEDED IN A HOSPITAL BASED HMO, WHEREAS, IN PUBLIC PLANNING, 4 TO 5 BEDS PER THOUSAND IS THE NORM (NOTE HEW'S RECENT GUIDELINES). HOW IS THE EAST COAST AND THE WASHINGTON AREA, IN PARTICULAR, TO GET A DEMONSTRATION OF THIS FACT IF ALL NEW HOSPITALS ARE BANNED?

THE ISSUE IS IMPORTANT. THE WASHINGTON HOSPITAL CENTER AUTHORITIES HAVE MADE WHAT SEEMS TO US TO BE AN INGENIOUS AND USEFUL PROPOSAL, USEFUL TO THE CITY, TO WASHINGTON HOSPITAL CENTER, AND TO GHA. IT HAS OFFERED TO GHA AT A NOMINAL RENT A TRACT OF LAND ON ITS CAMPUS ON WHICH GHA WOULD BUILD ITS OWN HOSPITAL OF ABOUT 150 BEDS. THE WASHINGTON HOSPITAL CENTER WOULD GIVE UP 80 OF ITS BEDS TO GHA IF THE CITY WOULD AUTHORIZE THE OTHER 70 BEDS

TO GHA. GHA WOULD SEND ITS COMPLICATED CASES TO WASHINGTON HOSPITAL CENTER (7% OF ITS BED NEEDS), CONTINUE ITS PEDIATRIC CARE AT CHILDREN'S MEDICAL CENTER (3-4% OF ITS BED NEEDS), PROVIDE OBSTETRICS AT THE HOSPITAL CENTER (10% OF ITS BED NEEDS), AND PROVIDE 80% OF ITS MEMBERS NEEDS IN ITS OWN, LOWER COST HOSPITAL, ONE WHICH WOULD LIMIT ITSELF TO ROUTINE HOSPITAL CARE. WE WOULD GET OUR UTILITIES FROM ITS PLANT. WHY NOT BUY ALL ITS IN-PATIENT BED NEEDS FROM THE WASHINGTON HOSPITAL CENTER? BECAUSE, IT IS TOO EXPENSIVE. THE CENTER IS A MEDICAL TEACHING INSTITUTION WITH COSTS NOT TOO FAR BELOW THAT OF GEORGE WASHINGTON UNIVERSITY HOSPITAL AND GEORGETOWN UNIVERSITY HOSPITAL. ITS OVERHEAD COSTS INCLUDE SUCH ACTIVITIES AND CAPITAL ITEMS AS A LARGE RESIDENCY PROGRAM, THE WASHINGTON AREA'S BURN CENTER, A MILLION DOLLAR CAT SCANNER, AND OTHER USEFUL AND LIFE-SAVING EQUIPMENT. WITHOUT DISCUSSING WHO SHOULD BEAR THE COSTS OF THESE COMMUNITY ASSETS, GHA COULD NOT SHARE IN THEM AND SURVIVE IN THE COMPETITIVE MARKET-PLACE. HOWEVER, GHA WOULD USE THESE FACILITIES AS NEEDED AND, IN THAT WAY, WOULD USE THEM IN A COST-EFFECTIVE MANNER. WE WOULD PROVIDE ROUTINE AND UNCOMPLICATED HOSPITAL CARE IN A MOST ECONOMICAL WAY.

MANY DIFFERENT KINDS OF INITIATIVES ARE POSSIBLE WHEN EXPERIENCED PEOPLE ARE ENCOURAGED TO INNOVATE. ARE THESE TO BE WIPED OUT BECAUSE THERE IS AN ABSOLUTE LID ON BEDS IN THIS AREA? PARENTHETICALLY, I MIGHT NOTE THAT THIS PROPOSAL CAN BE IMPLEMENTED WITHOUT TAKING AWAY ANY BEDS AND BY ADDING LESS THAN 10 BEDS TO THOSE NOW ON THE APPROVED ROLLS HERE IN THE DISTRICT. THE DISTRICT'S DHR DIRECTOR, MR. RUSSO, APPROVED A RENEWAL CERTIFICATE

FOR DOCTORS HOSPITAL AT ABOUT 60 BEDS LESS THAN ITS PRESENT AUTHORIZATION. TOGETHER WITH THE 80 BEDS THE WHC IS WILLING TO GIVE, THIS WOULD MAKE 140 OF GHA'S 150 BED NEED. AT ITS PRESENT RATE OF GROWTH, GHA WOULD OCCUPY ITS NEW HOSPITAL ON OPENING DAY AT A HIGH LEVEL OF OCCUPANCY AND BE AT CAPACITY IN LESS THAN 6 YEARS.

ANOTHER CONSIDERATION FOR THE D. C. HEALTH PLANNERS IS THE "BLEEDING" OF HOSPITALIZATION TO THE SUBURBS. PHYSICIANS WILL FOLLOW HOSPITALS AND POPULATION. IN SPITE OF THE FACT THAT EVERY SUBURBAN JURISDICTION IS OVERBEDDED, HOSPITALS ARE PLANNED, GOING UP OR RECENTLY COMPLETED IN FAIRFAX, PRINCE GEORGE'S AND MONTGOMERY COUNTIES; INDEED THERE ARE THREE SUCH IN PRINCE GEORGE'S. IN TIME, GHA WILL BE UNABLE TO SAY TO ITS MEMBERS IT IS BETTER FOR YOU AND GHA FOR YOU TO BE IN A D. C. HOSPITAL THAN IN A SUBURBAN HOSPITAL, IF WE ARE NOT TALKING ABOUT GHA'S OWN HOSPITAL, IN WHICH WE WILL HAVE RESPONSIBILITY AND CONTROL AS TO BOTH MEDICAL CARE QUALITY, PROCEDURES AND COSTS.

ANOTHER EXAMPLE: GHA WAS DELAYED FOR SEVERAL MONTHS LAST YEAR IN ITS PLAN TO BUILD A MEDICAL CENTER IN THE NEARBY MARLOW HEIGHTS (PRINCE GEORGE'S COUNTY, MD.) AREA - WHILE GOING THROUGH FOUR SEPARATE HEARINGS BEFORE THE HEALTH SYSTEMS AGENCY OF SOUTHERN MARYLAND CONCERNING OUR CERTIFICATE OF NEED APPLICATION RELATING TO THAT CENTER. ONE OF THE PROBLEMS - IN THAT AGENCY'S VIEW - WAS THAT GHA WOULD NOT AGREE TO HOSPITALIZE OUR PRINCE GEORGE'S-GHA MEMBERS IN PRINCE GEORGE'S COUNTY HOSPITALS. THIS WAS AT A TIME WHEN THREE NEW HOSPITALS WERE GOING UP IN THAT COUNTY - IN ADDITION TO ALL THE OTHER HOSPITALS ALREADY IN OPERATION THERE.

OUR POINT HERE IS THAT - WHILE OUR IMPACT UPON AREA PROVIDERS IS SLIGHT - IT IS A HEALTHY THING - ECONOMICALLY AND IN TERMS OF COMMUNITY SERVICES GENERALLY - TO HAVE COMPETING HEALTH CARE SYSTEMS OPERATING IN A NEIGHBORHOOD. ALSO, WHILE WE HAVE NO PROBLEM WITH BEING INSPECTED AND REGULATED BY HEALTH AGENCIES, WE DO HAVE PROBLEMS WITH BEING ASKED TO BAIL EACH OF THE LOCAL COMMUNITIES OUT WITH THEIR HOSPITAL BED PROBLEMS. WE SUGGEST THAT THE COMPROMISE POSITION WHICH WE HAVE ADOPTED IN REGARD TO OUR HOSPITAL NEEDS (SET FORTH ABOVE) WILL WORK OUT WELL FOR GHA, OUR MEMBERSHIP AND THE GENERAL MEDICAL COMMUNITY.

I CITE, WITHOUT ELABORATION HERE, THAT THE U. S. CONGRESS HAS RECOGNIZED THE POTENTIAL OF HMO'S IN PROVIDING MORE COST EFFECTIVE MEDICAL CARE IN THE HMO DEVELOPMENT ACT OF 1973 AND IN THE PUBLIC LAW 93-641 -- THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 -- AND, IN BOTH, REQUIRES THAT SPECIAL CONSIDERATION BE GIVEN TO THE NEEDS AND POSSIBILITIES OF HMO'S. WHAT WE SEEK NOW IS AN OPPORTUNITY TO FULFILL THAT POTENTIAL.

OUR PLEA, THEREFORE, IS FOR PLANNING WHICH DOES MORE THAN JUST MAKE A BED COUNT; WHICH ENCOURAGES NEW INITIATIVES; WHICH TAKES INTO ACCOUNT TRENDS AND DEVELOPMENTS AND WHICH FACES HARSH ECONOMIC FACTS. IN THE PRIVATE, COMPETITIVE SECTOR OF THE ECONOMY, COMPETITIVE FORCES ELIMINATE THE UNNECESSARY, THE INEFFECTIVE AND OBSOLETE. PUBLIC AUTHORITY NEEDS TO PLAY THIS ROLE IN THE FIELD OF MEDICAL CARE, WHICH IS NOT AS SUBJECT TO COMPETITIVE PRESSURES.

BOTH OF THESE LAWS NEED AMENDMENTS OF THE TYPE WE ARE SUGGESTING IF THEY ARE TO CARRY OUT CONGRESSIONAL INTENT.



Mr. PREYER. Thank you very much for a very informative presentation.

Let me ask you one question of sort of general interest not too directly related to what you are doing.

Mr. LANE mentioned there was no need to control the growth of HMO's. I was visiting an HMO in Winston Salem, the Reynolds industry. They don't call it an HMO, but that is what it really is. That indicated that that was the first corporate HMO since the Kaiser plan. Is that right? Has there only been one corporate foundation?

Mr. LANE. I believe that is correct. Our organization was sponsored by the Kaiser industry when it first started. It is much broader than that now. It covers 3.3 million people. There is a substantial increased interest among the corporate community in fostering the development of health maintenance organizations. The Ford Motor Co. is examining the possibility and a number of other large corporate organizations are and I think there will be increased interest.

One of the basic problems, when corporate managers start looking at the issue, is all the Government controls they have to go through to get established. That is something they have to look at carefully. Most of them are very amazed to find out what you have to go through to start and get approved for HMO in terms of Government approval.

Mr. PREYER. That is a very impressive operation they have. I hope your plan and that one will interest a lot of other corporations.

Just one question. You recommend that States be prohibited from including HMO's under their certificate-of-need laws. How many States have those laws that include them now?

Mr. LANE. I don't know that. I am sorry. I only know of the States in which we operate. We operate in six, two due and two are considering it. California will be considering it. It is my understanding a number of States in the East do.

Mr. PREYER. Those laws would allow an HMO to build a hospital even if the HSA found excess beds exist in that community; is that right?

Mr. LANE. The existing laws?

Mr. PREYER. If you exempt it or if States were prohibited from including HMO's under their certificate-of-need laws, that would allow an HMO to build a hospital even if HSA found there were excess beds?

Mr. LANE. Yes, sir. I would like to address your attention to exhibit 1 [see p. 1029] of our testimony, one of the basic arguments for not allowing HMO's to build when there are excess beds in the community is that it increases the cost to the community. The study portion of which is presented in exhibit 1 was done for HEW by ICF, Inc. It is a careful study of whether that is true. They found it is not true. Even where there is excess bed capacity in a community, the introduction of a cost effective HMO and the building of its own hospital will result in a total reduction of community cost. I think that is a very significant point.

Mr. PREYER. I can see your point, however as to how it will restrict innovative plans it does make a liar out of some of our statistics where we just say "X" number of beds in excess means "X" dollars of extra cost. It does not necessarily mean that apparently.

Mr. LANE. Yes, sir. I would like to give an example. The State medical facility plan guidelines which came out the middle of last year set as one of the highest priorities 80 percent occupancy. The country is running about 75 percent now or somewhat below that. If your major objective is to have the hospitals running at 80 percent occupancy, there are only two ways to accomplish that; that is close some beds in hospitals, secondly, have more people getting hospital care.

The problem is that it is unlikely, despite what may be in this bill at the present time, that hospitals will be closed by Government fiat in the near future, closing for other reasons but not Government fiat. If your objective is to keep occupancy higher and HMO proposes to build or expand and one of the characteristics of HMO is they have low utilization, utilize substantially less, they will fight that that objective of high occupancy because they will drive occupancy down. That is an important objective to drive occupancy down, not up.

I don't believe the planners understand that. Low occupancy is not bad. In California the hospitals run at 60 percent occupancy on the average, yet their days per use are 300 or less days of hospital care per thousand persons, more than 300 less than the national average. It is not evil to have low occupancy. It is important to have it until the beds come into balance. Our institutions don't run at high occupancy either but are cost effective.

Mr. PREYER. I didn't mean to cut you off, Mr. Walgren. We do have a vote.

Mr. WALGREN. Maybe a couple of minutes.

First, it is my understanding that you would not need a certificate-of-need for any outpatient facilities developed by HMO; is that correct?

Mr. LANE. Under this proposal, that is correct.

Mr. WALGREN. What are the difficulties of using presently existing hospital facilities by a developing HMO, are those mainly political problems of access?

Mr. SEGADELLI. For a developing HMO there is no alternative. It is because you don't have the membership or resources, but at a certain point it becomes possible but that becomes possible at a enrollment between a 100,000 and 125,000. That is where we are. Then you can begin to achieve many economies which you can't achieve when using someone else's hospital. It is not a question of running the hospital better but you can eliminate a lot of duplication.

Mr. WALGREN. What you are essentially doing, you are pulling patients away from the other hospitals at that point, you are competing for provision of services?

Mr. SEGADELLI. Sure.

Mr. WALGREN. The question becomes whether or not those services should be provided with existing systems or whether a new facility that can provide certain economies of scale, a new administration process—

Mr. SEGADELLI. Not only economies of scale. For example, an HMO using a community hospital has to have its own medical records and have a medical record in the hospital, have its own X-rays and X-ray in the hospital, own lab tests and lab tests in the hospital, which if it

ran both it could provide in one way and it has to pay the overhead on whatever the hospital decides the hospital will have, whether the HMO thinks it is smart or not, CAT scanners, for example, or open heart surgery teams to get proliferated around the community.

I have essentially answered the question. I think there are savings in the HMO's having their own hospitals that are not only possible if they buy from other institutions and are not related to scale alone but to unnecessary duplication and overhead and things like that.

There are some other problems with using community facilities. In the first place, a bed is not necessarily a bed. All beds are not the same. They are not in the right places. You cannot use a pediatric bed for adults. Planners don't take that into consideration. Even though there are too many beds they may not be the right kind of bed.

Second, the medical staff may be opposed. We have been trying to use hospitals in southern California. They go to vote with the medical staff, absolute opposition. In addition, there are other problems. The long-term relationship is very important. We have to build an ambulatory care facility beside the hospital to care for outpatients. Unless the hospital will enter into long-term arrangements, we can't do that. Those criteria are set forth on page 7.

Mr. WALGREN. Thank you.

Mr. PREYER. Thank you. We have to go vote now and will recess at this time until 2 o'clock this afternoon when the panel of equipment manufacturers representatives, I believe, will be the first up.

The committee stands in recess until 2 o'clock.

[Whereupon, at 12:30 p.m., the committee recessed, to reconvene at 2 p.m., the same day.]

#### AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, presiding.]

Mr. ROGERS. The subcommittee will be in order.

Continuing our hearings on health planning and resources development, we have a distinguished panel of Governors which we welcome to the committee and I would like to ask Dr. Carter first to have a comment or introduction.

Mr. CARTER. It is my pleasure to introduce the Governor of the State of Kentucky, the Honorable Julian M. Carroll.

Thank you.

Mr. ROGERS. We are honored to have you and Governor Herschler of Wyoming. We do appreciate both of you coming here to help the subcommittee. We are anxious to work with the Governors in trying to develop a health planning system that will be effective. I think it is a most important piece of legislation and we doubly appreciate your being willing to give us your time to be of benefit in our thinking.

#### STATEMENT OF HON. JULIAN M. CARROLL, GOVERNOR, STATE OF KENTUCKY

Governor CARROLL. Mr. Chairman, Congressman Carter, Congressman Walgren, we appreciate the opportunity of coming today. I have an airplane that leaves here at 3 o'clock and will try to immediately proceed into my testimony.



I am going to not read it because obviously it is easy for me to file it with the committee and I will try not to take longer to explain it than it would be to read it.

Mr. ROGERS. That will be a refreshing approach from some of the witnesses we hear. Your statement will be made a part of the record in full, without objection [see p. 1050].

Governor CARROLL. We think that there are some movements that can be made in this legislature that would vastly improve our ability to make it work.

In Kentucky we were fortunate enough prior to the implementation of this legislation to have an excellent planning system. We have had it in operation in Kentucky for about 15 years. We have area development districts that were implemented in our Commonwealth about 15 years ago and those districts have been involved in health planning in our State for a long time. Thus, it was easy for us just to take those districts and divide them along their geographical boundaries and set up our HSA's and just go on to work.

We still do have some problems, though. In one particular instance we have three counties in the north side of Kentucky that I can't get the government of Ohio to let me have to put into my system. I did get the Governors of other States that have our counties to agree so we could operate as an entity. Because of the law and the other Governors, I have three counties under control of the Ohio legislature and we have to report six Ohioans on my State Board to oversee this statewide program. We believe that would then give them a disproportionate share of the oversight of this operation. Surely we don't think the committee ever intended that.

I am an old legislator myself, spent 10 years in the Kentucky Assembly, and beg forgiveness for my mistakes. I am essentially suggesting it is the kind of thing you could not anticipate would happen, but those are things that have happened to us.

Mr. ROGERS. Have you suggested language in your testimony?

Governor CARROLL. Not as such, Mr. Chairman, but we would be happy to do it.

Mr. ROGERS. Thank you.

Governor CARROLL. The Governors Association has, I am advised. That takes care of that particular problem.

Additionally, while at this time we are having no problem at all in getting along with the people involved in our two HSA's—we have two in Kentucky—nor do we anticipate any problem with our overall State coordination council, but we do seriously think that it has the great potential for fragmentation and disorientation because there is little or no involvement by State government, who after all, in our judgment, has the overall responsibility for implementing our health planning program in the State.

We have county health departments. We have regional health departments that we designate in some of our counties that have the capacity to reach into other counties that don't have our comprehensive care centers, which is one of the best examples of how not to set up something in Kentucky. We are now working on the problem of how to take those health care centers and make them work since we are losing Federal funding for them. We have that problem in the

current session of the general assembly. They are essentially independent bodies and essentially have just gotten reimbursement of Federal dollars through our State agency and we have had little ability to make them implement statewide policy programs, and so that is what we are fearful we are headed for with our current operation of the HSA's if we don't make some of the slight changes we are suggesting.

I guess one of the most important things for me to suggest to you in my testimony is that I do not believe that I can go to my general assembly and ask for appropriation of dollars, at present about \$130 million a year in Kentucky, and then be able to implement our health planning programs in Kentucky without some authority to be a participant in the total policymaking function.

At the moment with the bill as we presently read it, the Governor is totally separated from the decisionmaking implementing State health planning policy, and we seriously think that the Governor ought to participate in that planning operation.

Mr. Chairman, I could cover some other elements, but they are covered in my testimony. I would prefer to use my remaining time to try to answer some questions for you and the members of the committee.

I thank you.

[Governor Carroll's prepared testimony follows:]

#### STATEMENT OF GOV. JULIAN M. CARROLL, GOVERNOR, STATE OF KENTUCKY

CHAIRMAN ROGERS, GOVERNOR HERSCHLER, I am delighted at the opportunity to be here to discuss with you some of our concerns about the National Health Planning and Resources Development Act of 1974 [Public Law 93-641]. We recognize that the intent of this legislation is to upgrade nationwide our health planning effort, and to enact in each State certificate-of-need legislation. These are essential prerequisites for improving the overall level of health care in this country.

There are, however, problems with 93-641 which Congress was obviously not able to anticipate at the time the legislation was enacted. One of our major overall concerns is that the legislation did not recognize differences between the States in problems and needs, or the State's previous efforts in health planning. Two of the major benefits of this legislation—comprehensive health planning and improved funding levels for planning—already were in effect in Kentucky in 1974.

Kentucky is divided into 15 standard districts, and all regional planning groups—such as Manpower, Aging, Criminal Justice, and Health—plan for the same geographic area. Our State agencies also are structured to offer services by district.

This system was in place in 1974, and each of our 15 districts was served by professional health planning staff.

As for funding, Kentucky in 1974 was supplementing the planning money available from HEW with funds from the Appalachian Regional Commission and a significant amount of State funds. In fact, the level of funding for our 15 health planning districts in 1974 was only \$100,000 less than the funding for our health systems agencies during their first year of operation.

So Kentucky began implementing Public Law 93-641 from a position of strength. After some experience with its workings, we have found some problems which I would like to discuss today:

We feel that 93-641 circumvents the authority and expertise of State government, by setting up a direct relationship between the Federal Government and health systems agencies. It is inappropriate for private, nonprofit, self-perpetuating boards like the health systems agencies to have the kind of au-



thority implied in Public Law 93-641 and in subsequent directives from HEW. It has been our experience that these boards should not administer Government programs without significant State oversight, monitoring, and technical assistance.

This kind of situation has created problems with our 15 mental health-mental retardation boards which operate Kentucky's community health centers. These boards have used Federal funds and expanded programs to a level that cannot be maintained with State and local funds, now that Federal aid is winding down.

We think it is inappropriate that a citizens advisory group, the statewide health coordinating council, is allowed to submit health plans to HEW without the Governor's approval. After all, the Governor is the person who has the best overall concept of his State's needs, available alternatives, and resources.

The detailed requirements concerning health systems agency membership are too restrictive, especially the one that says a consumer on another board or committee becomes an indirect provider when considered for membership in a health system agency.

Some of Kentucky's leading citizens serve on a local emergency medical board, a hospital board, or local health department board, but they could not be considered for consumer appointments to a health systems agency.

Our existing certificate-of-need law in Kentucky is one of the best in the Nation. We are concerned that 93-641 and subsequent regulations will necessitate changes in the legislation. Kentucky enacted a certificate-of-need law in 1972. We feel that it is a good law and that it has been effective in controlling expansion in construction and services.

The law's provision for maintaining standard metropolitan statistical areas without the concurrence of the Governors involved also has caused Kentucky some problems.

As you know, the population base for health systems agencies was established at 500,000 with the possibility of waivers for smaller agencies in some cases. The legislation also said that if the Governors of neighboring States agreed to split a standard metropolitan statistical area, the Secretary of HEW could grant a waiver.

Although we had reservations about the population base for health systems agencies, we decided not to make an issue of it but rather chose to designate two agencies, each with a population of roughly 1½ million people. The Commonwealth of Kentucky was basically divided down the middle with an eastern and western Kentucky health service area.

We felt that this would enable us to coordinate health planning on a wider basis. But we also felt sure that the health systems agencies, once established, would build on the foundations developed by the 15 districts. In fact, both of our agencies have recognized the boundaries of the old districts as their sub-area council areas.

The standard metropolitan statistical area provision was a much more significant problem, and we requested waivers for all five areas in which we were involved. With one exception, all of the Governors involved agreed with our request.

HEW approved all of our requests except the three counties in northern Kentucky adjacent to Cincinnati, Ohio. We submitted a redesignation plan last year calling for reuniting Boone, Campbell, and Kenton counties in Kentucky with the eastern Kentucky health systems agency, and we are still awaiting a final decision.

Our desire for redesignation should not be interpreted as opposition to interstate planning. We are committed to complete cooperation with our neighboring States in planning for the population of all five standard metropolitan statistical areas.

We think that adequate cooperation could be achieved through interagency coordination at the State level and between the health systems agencies, and we would be happy to pursue an interstate compact agreement with the State of Ohio in this regard.

Without redesignation, an Ohio-based health systems agency which represents 300,000 Kentuckians would have equal representation on our statewide health coordinating council with our eastern and western Kentucky health systems agencies, each with populations of approximately 1.5 million people.

Neither the law nor subsequent regulations require that Kentuckians be nominated. I could be forced to appoint six citizens of Ohio to our statewide health coordinating council.

We believe that, with some modification, 93-641 can work. We suggest your consideration of the following amendments:

The State should have more opportunity for significant contributions to the final statewide health plan. As it is now designed, the State health plan is merely a composite of health systems agency plans and the State is not an equal partner in formulating it. Also, we feel that a plan should not become final until it has been approved by the Governor of the State.

The Governor, and not the statewide health coordinating council, should make the final recommendation concerning approval or disapproval of any formula grant to the State.

The Governor should be allowed to name the chairperson of the statewide health coordinating council.

The council's recommendation concerning Federal funds allocated to the States should go to the Governor and not directly to the Secretary of H.E.W.

The consumer criteria for membership on a health system agency should be less rigid.

All Governors involved should be required to agree to maintain an interstate standard metropolitan statistical area within the same health service area. Without such agreement, the metropolitan area should be automatically split.

The present time frame provided for review of certificate of need applications is inadequate and it should be extended to allow a 180-day review cycle.

Without these amendments, we seriously question the long-range effectiveness of Public Law 93-641. There is a strong implication in the legislation as it currently exists that State government is not to be trusted, and that a separate system outside State government must be set up in order to provide quality health planning and to contain costs. We believe that the Kentucky experience refutes this belief. Our health planning efforts have been effective because of the development of a local-State partnership, and we think this partnership should be encouraged at the Federal level also.

Thank you.

Mr. ROGERS. Thank you. We appreciate your helpful suggestions. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

When this became a law, Governor, I realized that we had area development districts, and I did my best to make an imprint on the law to that effect. It was rather difficult, but we did provide that, under certain conditions, recognition of previously-established planning districts would be allowed. In fact, Bill Alexander, the Honorable Bill Alexander from Arkansas, even went further on the floor of the House to make this possible.

I personally, well, I hope it is working the way we planned with the HSA's for the two parts of the State. I support your idea of taking the three counties. You would like those counties to be in the eastern HSA; is that correct?

Governor CARROLL. That is correct.

Mr. CARTER. I think that we could very well do that. Again, I want to compliment you on what you said about the comprehensive care centers. I think you need assistance there.

You are talking particularly in reference to mental health; is that correct?

Governor CARROLL. Yes, sir. That is correct, Dr. Carter.

Mr. CARTER. You don't think—I brought this up before the chairman before, this very thing you are talking about. Tell us a little of the difficulty you are having, if you would like.

Governor CARROLL. I would love to. This may be slightly off the major subject matter, but I know it is an area the committee is much concerned with. Our comprehensive care centers in Kentucky are operated as independent self-perpetuating boards of citizens and, of course, they merely set up their own budget and then under Federal criteria apply to us for reimbursement. We have had a terrible time trying to audit them and stay abreast to make sure they spend their dollars properly. That is our only control over them. That is the approval of their dollar expenditures. They are not accountable under our State merit system or the State purchasing system, not accountable under the State transportation system and they really have had a lot of fraternizing in our State where one scratches the back of the other to the extent it has caused some embarrassment in the past.

We think we have solved most of those problems but the immediate problem now in trying to resolve their continued funding is we already have county health departments and regional health departments and now we have a comprehensive center that is somewhat duplicative of our own State-funded functions. So we are trying to resolve that present duplication between the two of them.

Mr. CARTER. You really think we should take existing State agencies and build on them.

Governor CARROLL. Yes, I do.

Mr. CARTER. How about these comprehensive health centers, have they been effective in drug abuse or alcoholism? I understand they were set up for those two things especially, and for mental health.

Governor CARROLL. They have been effective. Obviously some have been more effective than others where they had good personnel, good management personnel and good citizen boards.

Essentially that brings on the major problem. There is no capacity on our part to make sure that they all operated efficiently because other than our flow of dollars, which after all was an after the fact, you know when you work under a reimbursement procedure, we are simply trying to audit their previous expenditure of the dollars and then our only control over them is the future flow of other reimbursed dollars.

So as long as you are always paying the money after it has been spent, it is a little difficult to get them to correct procedures wherein we find faults.

Mr. CARTER. Governor, I want to say that in some areas these centers are very helpful. I can name one that is based in Corbett and one in Somerset that are quite good. I have had extreme difficulties with some others and I just don't see that they have done anything about alcoholism or about drug abuse, one particularly which involves my area and that of another Congressman. I am sure you are familiar with it, but certainly I agree with you somebody that should take the trouble to make these programs work.

Governor CARROLL. I would make one other assessment because I think it is so applicable to our HSA problem. I am often amused by somebody telling me, "All you want to do is play politics with something." I have been in public service for 18 years and the only distinction I have ever found in the use of the word "politics," first



of all, is whether or not it is in the public interest or in somebody's private pecuniary interests.

I try to deal with politics in the public interest as I know Congressman Carter does. The difference I find between a State government being involved in this, or a self-perpetuating board, is whether we play State government politics or the State board politics. You never remove politics totally from any operation. The question is whether they are applying mine or theirs. That is to put it simply.

We want those boards to be responsive and not be like these three comprehensive care center boards who are self-perpetuating and are not responsive. Some of them are but most are not.

We want to make sure that these HSA boards are responsive to the people that they serve.

Mr. CARTER. The Kentucky Mental Health Association has stated that these programs were not too effective in some areas. The executive director of KMHA in Louisville visited with me. They are very fine people who strongly back the program but the most effective part has been the program for mentally retarded children as far as I have seen. There are others in our system. The nursing system has been excellent in some areas where we have provided service to home-bound people.

Thank you very much.

Governor CARROLL. Thank you.

Mr. ROGERS. Mr. Walgren.

Mr. WALGREN. No questions.

Mr. ROGERS. I assume you have a certificate-of-need board in your State?

Governor CARROLL. Yes, sir, a fine certificate-of-need board. The Governor appoints the board but its decision is final. I have no authority to overrule or veto the decisions of that board. It has been in operation since 1972.

Mr. ROGERS. You probably prefer not to have that authority.

Governor CARROLL. You are totally correct. I prefer not to have that authority. Quite frankly, the law that now places it into the department creates a problem for us. We just as soon it be left to our major board and, quite frankly, there are some misinterpretations of the applications approved by those boards. Ours is often criticized because they approve most of the applications that come before it. As a practical matter, if the application isn't worth much, it never gets there because we have about four methods it must go through to get there and they work so much with the staffs, knowing their application may be denied. Rather than letting it be denied they withdraw it because they don't want to come before the board with a previously denied application. We have found it works very, very effectively in Kentucky.

May I add a slight comparable is we now have legislation before our general assembly in Kentucky I am going to support for cost containment, creating our own cost containment board in the Commonwealth.

Mr. ROGERS. We commend you for that because this committee is hopeful the States will move and in the legislation Dr. Carter and I proposed—

Governor CARROLL. I appreciate your saying that.

Mr. ROGERS [continuing]. We have the mechanism for the State to come in and do their own cost containment, which we think is better.

Thank you for being here. Your testimony has been most helpful. We may be back in touch to get some of your thinking on things as they come up.

Mr. CARTER. The director of that association is Ashley Tulles.

Governor CARROLL. Right.

Mr. ROGERS. Now, we are very pleased to have the distinguished Governor of Wyoming, the Honorable Edward Herschler.

We welcome you and thank you for coming.

## STATEMENT OF HON. EDWARD HERSCHLER, GOVERNOR, STATE OF WYOMING

Governor HERSCHLER. Thank you, Mr. Chairman.

I am very grateful for the opportunity to be able to appear here today and discuss the problems of the National Health Act.

I have a statement and will cover parts of it [see p. 1056], but hopefully there are other matters we can go into.

Mr. ROGERS. That will be fine.

Governor HERSCHLER. Let me preface my remarks by stating that Wyoming has a single statewide health agency. Consequently, I think most of my remarks will be directed in regard to that particular situation.

We are concerned there with the interrelationships between the health systems agency, the State health planning and development agency and the statewide coordinating council. It is a system with a single statewide health systems agency and there is a relatively complex relationship and interaction among those various agencies which I do not believe the Federal Act seriously concerns itself with or even contemplated when this was done.

In effect, the health systems agency now assumes the role of the state-level agency and by doing so has authority, as I see it, to exceed a state agency in the relationship of health care.

What I am here today for was to see whether my State or other States with a similar situation could take advantage of section 1636 of the law. I presume to become involved in that area so we would not have a health systems agency in Wyoming.

As you know, the law, as it now exists, complements or allows the State of Rhode Island and the territories to come under section 1536 and so what we are doing here, we are asking that Wyoming be permitted to take a waiver under section 1516 or possibly as an alternative to permit my State to have two health systems agencies within the State, although we would prefer to be able to take advantage of 1536. The next best bet we feel would be to have two HSA's in our State.

I think what I have done basically in my State is to have the State health coordinating council as part of the same members of the HSA. I was able to work with the group and made those original appointments and then also appointed an executive council of the HSA.



The reason I have done that is a matter of economics in our State. We have only a population of less than 400,000. We have 100,000 square miles so you can see what we have in our State.

The health system agency already spent about \$22,000 of its budget of \$175,000 for travel. So this is why I have not added additional people. It is a matter of economics.

Another problem that we have on this particular situation is the trying to find people to serve on this committee. Many are, as you know, required to be consumers and providers and many of those consumers and providers are self-employed and we find it very difficult to get people to keep any interest in this by having to attend at least two meetings a month and travel great distances. So actually only the larger health care providers, the rich, I suppose, or the retired tend to accept these nominations and appointments to SHCC or HSA.

One of the other burdens we have is I am able to appoint 40 percent of the people to SHCC and 60 percent come from HSA. If we follow this line of reasoning, it creates antagonism, I suppose, to the State.

So basically I would urge the committee, if it will, to recognize either that we should be able to get a waiver under 1536 or to have two HSA's. I will leave the balance to your questioning, sir, if you have any questions, and I will leave my prepared statement with you for the record.

[Governor Herschler's prepared statement follows:]

#### STATEMENT OF HON. EDWARD HERSCHLER, GOVERNOR, STATE OF WYOMING

Mr. Chairman, My name is Ed Herschler. I am the Governor of the State of Wyoming. I am grateful for this opportunity to testify on our experience with the National Health Planning and Resources Development Act of 1974. Let me preface my remarks by stating that Wyoming has a single statewide health systems agency. Consequently, my statements will be directed toward this type of structure.

I am deeply concerned about the interrelationships among the Health Systems Agency, the State Health Planning and Development Agency, and the Statewide Health Coordinating Council. In a system with a single statewide health systems agency, the relatively complex interaction among the various agencies as contemplated by the federal Act becomes seriously imbalanced.

In effect, the Health Systems Agency assumes the roll of a state-level agency with authority exceeding that of the state agency. Since there is only one health systems plan, the state agency need only add those programs totally financed by the state in order to have a complete state health plan. Proposed revisions are unlikely to be approved by the Statewide Health Coordinating Council since the executive committee of the Health Systems Agency is the Council. This incestuous relationship is carried to the point where the same person is the chairman of both organizations. The net result of this structure will be a wasting of finite health planning resources due to the nearly total duplication of efforts and the unproductive conflict that has been created.

The duplication does not end in the planning phase but continues throughout the review process. In those states with several health systems agencies, this overlapping of functions serves as a useful coordinative mechanism. However, in a state with only one health systems agency, there is little need for coordination. Thus, the only effects of the additional reviews are an increase in the bureaucratic burden placed on the citizenry and the creation of conflict between the two planning agencies.

The one major function of the health systems agency which is not duplicated in some manner by the state agency is the annual implementation plan. This

document becomes a statewide policy plan in Wyoming. Under the current provisions of the Act, priorities established in this plan are binding on the state agency. Consequently, the health systems agency can determine state policy without any input from state officials or agencies. I believe this situation goes considerably beyond the intent of the law.

In the spring of 1975, I appointed a committee to look into the requirements of this new legislation. The committee was composed of consumers and providers from throughout the state. After much discussion and deliberation, they recommended that Wyoming should seek inclusion under section 1536 of the Act, which would eliminate the need for a health systems agency. We were told by federal officials that this section applied only to Rhode Island and the territories, and that we should not waste their time and ours by pursuing that course of action. In retrospect, I regret not having insisted on the application for a waiver under section 1536.

My intent is not to malign the good people who have worked diligently as members of the boards governing the Health Systems Agency and the Statewide Health Coordinating Council. Under the circumstances, they have done an excellent job in implementing the law.

I do not question the applicability of this legislation to those states having more than one health systems agency. I cannot speak for them.

The achievement of equal access to quality health care at a reasonable cost is a high priority in the rural states where health resources are so scarce. Thus, my concern is not with the intent of the law.

However, I sincerely believe that the single statewide health systems agency structure inherently contains the seeds of conflict between the State Health Planning and Development Agency and the Health Systems Agency staff. My fear is that this discord will overshadow the planning efforts by these two agencies. In the end it will be the people of Wyoming who will suffer.

My request is that you consider the factors I have presented here today during your deliberations of amendments to the Act. Please review the appropriateness of the structure and authority currently contained in the law, as it is applied to states with a single health systems agency. I think you will conclude that states, such as Wyoming, will be served best by inclusion under section 1536. The intent of the law will remain, but the source of conflict will be resolved.

Thank you.

Mr. ROGERS. Thank you very much for the points you have raised for consideration of the committee.

Dr. Carter.

Mr. CARTER. It is interesting to note that the recent GAO report recommended there be no single HSA States. That is the General Accounting Office, an arm of the Congress. GAO recommended that those States either receive a 1536 exemption and have only a health planning agency and no HSA's, or those States should have at least two HSA's.

Governor HERSCHLER. That is right.

Mr. CARTER. Mr. Chairman, I believe that the law actually provides that States such as Wyoming can have two HSA's if they want them, and if they can prove the need for them, because we had that in mind. You remember that we worked with such a thing in mind and it was brought up on the floor. It is a question of HEW putting it into effect, as I see it, Mr. Chairman.

If it is necessary, I would help to legislate on this question because you do have a large State, and the problems of getting together, if you can get people to serve, are monumental.

Governor HERSCHLER. That is true.

I might add when this law was implemented, so far as our State was concerned, I am sure you realize it is a very complex and, if

you will, a confusing law, sir. I think that we were under the impression at least that we were required to make a decision at that point in time as to how many HSA's we wanted in our State. We felt in the interest of economics and considering the scarcity I suppose of population, we thought one HSA would be the right way to go. We feel now that that was not a correct decision, that we should be permitted, if we are able to do so without any problems, either to have two HSA's or being able to take advantage of the section 1536. We think our system as it originally was structured at the time this bill was enacted that we meet all the qualifications of 1536, it would be logical to be exempt.

Mr. ROGERS. I think the committee certainly wants to be helpful. I was just wondering, if you do qualify under 1536, how do you get broad citizen input?

Governor HERSCHLER. What I would plan to do, Mr. Chairman, is if that occurred, that with your State's Health Planning and Development Agency, that I would include then the members that are presently on SHCC continue with them so there would be citizen input along with our State agency. I think there would be coordination and cooperation which would be very helpful to us. So we would include our present members on the SHCC Council.

Mr. ROGERS. It is my understanding that you would either want to qualify for that exemption or have two agencies.

Governor HERSCHLER. Yes; one or the other. We would prefer to come under 1536. If that is impossible, we would prefer to have two HSA's.

Mr. ROGERS. Governor, thank you. We appreciate your being here and taking time from your busy schedule to do so. We look forward to working with you in this area.

Thank you so much.

Our next witness will be a panel of manufacturers representatives. Mr. Robert G. McCune, division manager, Radiation Imaging Product Division, National Electrical Manufacturers Association; and Mr. Harold O. Buzzell, who is president of the Health Industry Manufacturers Association.

We welcome both of you to the committee. Your statements will be made a part of the record, and you may proceed as you desire.

**STATEMENTS OF ROBERT G. McCUNE, ON BEHALF OF RADIATION IMAGING PRODUCTS DIVISION, NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION (NEMA); AND HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION**

Mr. McCUNE. Thank you.

I am here as a representative of the Radiation Imaging Products Division of the National Electrical Manufacturers Association (NEMA). This divisional trade group consists of 54 manufacturing companies of conventional medical and dental X-ray, diagnostic ultrasound, computed tomography, nuclear imaging and therapy medical technological equipment. In my brief comments today I



would like to share with you our industry views concerning national health planning.

My comments will be a brief summary.

First I would like to offer for your consideration several changes to H.R. 10460. We would propose that:

In section 202, dealing with National Health Priorities, under section 1502, that in the proposed paragraph (11), the word "under-utilized" be inserted between (of) and (duplicative);

In section 202, National Health Priorities, under section 1502, that paragraph (12) be revised to include the words "cost effective" between the words (of) and (policies);

Under section 218, certificate-of-need programs, that paragraph (7) of the proposed section 1527 amendment be revised as follows:

(7) For purposes of Sections 1523 and 1527, the term "major medical equipment" means single use medical equipment which is used for the provision of medical and other health services and which costs in excess of \$200,000.

In the first suggestion we feel that the inclusion of "under-utilized" will better clarify this priority by establishing more defined criteria than simply "duplicative."

The second suggestion of including the phrase "cost effective" we hope will encourage HSA's to carefully distinguish between policies for purposes of mere implementation and policies that will in fact work toward achieving efficient local solutions relative to problems of health care costs.

Our suggestion for redefining "major medical equipment" in paragraph (7) of the certificate-of-need programs section of the bill is due to the concern that in smaller hospitals, for example, construction of a new multiple patient service room would be requested under a normal certificate-of-need process. But the HSA could also ask for a listing of all the numerous but different types of medical equipment to be used in the patient medical room. If all the installed individual medical equipment were to be considered as an aggregate, it could result in a total dollar figure reaching or exceeding the certificate-of-need requirement for major medical equipment. We have also suggested that the certificate-of-need dollar threshold for major medical equipment be only that equipment in excess of \$200,000. We believe this should be considered to avoid the inclusion of lower cost basic medical equipment not envisioned to be covered under the certificate-of-need requirement. Such a dollar level would then allow the local HSA to deal with only major medical equipment of the high dollar-high technology type that is of concern.

We support the efforts of this committee to insure that national and local health planning is an effective approach to achieving a much needed reduction in the health care costs of this country. We would only ask that the role of medical technology be considered a necessary component of all such efforts to contain the rising costs of health care delivery, rather than being too often denounced as a major contributor to these increasing costs. Extreme indeed, when you consider that the diagnostic imaging equipment industry represents only about 0.6 percent of total health care expenditures.

I think there is widespread agreement that the twentieth century biomedical research and technological innovation have been re-

sponsible for profound improvements in human health. Some diseases have been eradicated; others can now be prevented; life itself has been extended; and much pain and suffering has been alleviated.

Further, I believe it fair to say that in a number of areas hospitals will have to look to greater utilization of medical technology to effect cost savings. It will be needed in more efficient and accessible emergency centers and out-patient clinics. It will be needed to replace older equipment with high operating and maintenance cost in order to reduce hospital expenses. It is also possible that some hospitals will have to turn to medical technology under new cost reduction measures in order to maintain adequate and safe patient monitoring. Yet, these same hospitals will be faced with artificial limitations on the use of new technology.

We would urge the Congress, and particularly this committee, to be sensitive and alert to any health planning cost containment policies that could inhibit the growth of medical technology, thereby institutionalizing inferior procedures and inefficient practices.

We also believe that another serious question that should be addressed is, what will the impact be on the development of new technology to meet future needs? Obviously, such development is an expensive undertaking with considerable commercial risk. It will become even less attractive to an independent technology manufacturer if its fair market potential is to be arbitrarily reduced or indirectly capped. Health planning legislation could well carry a secondary effect as to whether new technology is to be limited and also how the development may need to be funded.

Some of the concern I have expressed here today I think is best illustrated by the recently published revised proposed National Guidelines For Health Planning. We are specifically concerned with the proposed standard on computed tomographic scanner, but of more importance is the questionable logic of the whole procedure and basis for decision for many of the standards dealing with technological services and facilities.

On the guidelines for CAT scanners, it appears that this proposed HEW standard will be promulgated without full comprehension of the effect of the so-called minimum standard on the use of this technological equipment. Simply stated, the proposed CAT scanner standard will inappropriately restrict proper access to this proven diagnostic medical technology and serious put in question the industry's interest in further pursuing state of the art technology.

In terms of the major procedural issue I mentioned I would like to share with you the following facts. In late summer, 1977, an HEW study team was organized with representatives from the office of the Assistant Secretary for Planning and Evaluation and the office of the Assistant Secretary for Health. The study team was asked to conduct a month-long phase I study of DHEW systems approach to technology management. This phase I study, "Health Technology Management at the Department of Health, Education, and Welfare," was completed on or about November 7, 1977, in draft form as a report to the Secretary.

Because of DHEW's recent release of revised proposed National Guidelines For Health Planning, and because the majority of the



proposed guidelines deal with technological services and facilities, it is disconcerting to me to note some of the comments contained in the DHEW phase I study, "Health Technology Management at the Department of Health, Education, and Welfare," contained such comments as:

#### INTRODUCTION

What market incentive mechanisms can be used to stimulate development of lagging or absent beneficial and cost-saving health technologies?

The "action" agencies of HEW (e.g., BHPRD, medicare, medicaid and PSRO programs) lack both the staff to do technical evaluations of technologies and the links to knowledge development agencies through which they could ensure examination of technologies for which they need action-supporting information.

Much effort is placed on efficacy and safety evaluation, but considerably less is done about cost-benefit, cost-effectiveness, or general societal impacts of technologies.

The strategy recognizes that, at the Department level, we cannot hope to systematically address all existing and emerging medical technologies, expert estimates of which range of 8,000 to 150,000.

DHEW decisionmakers and other users are unable to effectively locate and use much of the new and existing information about technologies because they are unaware of its existence; it is not in a form understandable to them; or they lack the resources to integrate such information and bring it to bear in a timely manner.

BHPRD develops standards for access, supply and distribution (through the National Health Planning Guidelines) to assist State and local health planning bodies. A major problem cited by nearly every agency developing or using standards is the need to implement viable standards as quickly as possible and the inadequacy of the technical knowledge base for doing this \* \* \* In part, this state of affairs can be attributed to pressures to produce standards without delay. However, these failures will not be overcome without a far more integrated process.

In fairness, I believe this study is a positive effort to provide the proper technical expertise to HEW in order to properly assess technology in terms of patient and cost benefit. However, in the interim, it does evidence some support for the contention that health planning cost containment policies need careful analysis to insure a balanced objective on the growth of medical technology. There can be effective health planning with health care cost containment, but it should also facilitate, not impede, the research and development of technology.

Before closing, I would like to offer the following recommendation for your consideration.

Amend section 1503 of Public Law 93-641, National Health Planning and Resources Development Act, to increase the membership of the National Council on Health Planning and Development from 15 to 16 members. This would facilitate the addition of a qualified technology representative from the health care industry for purposes of bringing professional experience to the deliberations and recommendations of the National Council, particularly with reference to the National Council's responsibility for "(3) an evaluation of the implications of new medical technology for the organization, delivery and equitable distribution of health care services."

Thank you for the opportunity to appear here today and express these views.

Mr. ROGERS. Thank you very much, Mr. McCune, for a helpful statement and your suggestions.

Mr. Buzzell.

### STATEMENT OF HAROLD O. BUZZELL

Mr. BUZZELL. Good afternoon, Mr. Chairman, and you, too, Dr. Carter. It is good to see you again.

My name is Hal Buzzell and I am president of the Health Industry Manufacturers Association. Our 260 members produce virtually every medical product used in the health care system. These range from crutches to bandages to disposable plastic and paper products, to clinical laboratory products used to measure blood sugar, to surgical instruments and artificial hips, to computerized diagnostic equipment like the CT scanner. The industry numerically has relatively few giants; for example, the bulk of HIMA's membership—75 percent—has annual device and diagnostic sales of under \$10 million.

I would like first, in launching my discussion on the proposed changes in legislation before the subcommittee, to simply state that we support the health planning process and we support that with emphasis on the local level. Your actions 4 years ago in establishing this process are certainly beginning to show dividends. This will be evident in our discussion on certificate-of-need (CON) approval rates for computed tomographic scanning equipment in a few minutes.

Health planning should encourage cost-effective patient benefits. All of our companies are affected by the health planning system to one degree or another. We understand the importance of planning; sound corporate management demands it. Simply said, our specific interest in the health planning system is that it encourage the appropriate introduction of cost-effective medical products and supplies so that the fruits of research and product development can be translated into patient care.

Therefore, it is our concern that the health planning process proceed: Openly, so that all points of view on patient benefits can be heard; soundly, so that the best evidence on all factors, including cost-effectiveness, can be utilized in planning decisions; efficiently, so that patients and providers can promptly benefit from cost-effective facilities, services, and products.

A great deal of talk these days assumes that technology is a part of cost and quality problems, not part of their solution. We believe, on the contrary, that it is only through innovation, in products, facilities, services, management, that patients will truly benefit from a system that achieves the best care at the most reasonable price. In order to assure that the planning system encourages the appropriate utilization of technology, whether they be CT scanners or other products, we recommend that the planning law be amended in the following ways:

One: To include, as a factor to be taken into account in developing national planning guidelines and in reviewing proposed health systems changes, the affirmative responsibility of the health plan-

ning system to assure the prompt and reasonable utilization of cost-effective medical technology. For example, in section 1502 we would recommend a 13 national health priority stating this responsibility.

Two: To provide special criteria for research institutions as they make equipment purchases or capital expenditures.

Three: To revise the definition of "indirect providers" for purposes of determining representation on HSA governing bodies by making clear that makers of all kinds of medical products are eligible to participate.

Four: To require that one to two members of the National Advisory Council on Health Planning and Resources be representative of indirect providers knowledgeable about the cost-effectiveness of medical technology.

Five: To reduce the obstacles to replacing obsolete or less cost-beneficial equipment.

These are our suggested additions to your amendments.

Next I wish to briefly comment on certain amendments embodied in H.R. 10460 which may impose too many new responsibilities on the health planning process at this time.

As you know, the health planning system created in 1974 through the efforts of this subcommittee, has a sound basic idea: to take, from a local perspective, a comprehensive look at the needs for health facilities and services. This basic idea is just being implemented. For example, as the HEW testimony this week reported, only 9 of the 205 health systems agencies are fully certified. Therefore, although hopes are high, the HSA system is in its infancy. What it most needs is a stable environment to grow.

We fear that certain amendments proposed by your bill, H.R. 10460, and suggested by the administration will prematurely encumber the planning system with unreasonable new responsibilities and layers of review. Now, when the HSA's and State level bodies are being started up, is not the time to add so many more demands on their capacities and resources.

Specifically, we propose the following:

One: The authority embodied in H.R. 10460 should be extended for 6 years, instead of the 4 years proposed in the bill. For at least the first 2 years, there should be a simple extension of existing authority with needed technical changes. In the later years, there could be extension of authority contingent upon a congressional review and finding that that system was ready for its new responsibilities.

Two: Authority to provide certificate-of-need and equipment review for noninstitutional health services should be removed or drastically reduced. Whatever the merits of these proposals may be, it is simply too soon to extend the planning authority so dramatically. If problems of abuse or avoidance of existing statutory provisions exist, we suggest that they be dealt with directly, rather than by blanketing the entire planning system with new responsibility that goes far beyond the abuse. We note that the Clinical Laboratory Improvement Act, recently approved by this subcommittee, provides an exclusion for individuals and small groups of practitioners; perhaps an analogous provision could be considered here.



Three: Similarly, appropriateness review, while recognized to exist in the current law, is provided added authority in H.R. 10460. We believe that this new authority simply represents too burdensome a task to levy on the States and HSA's at this time.

I have mentioned CT scanners in passing, but let me take a moment to use them as an illustration of where things can go wrong with the planning process.

First, let me say that the medical efficacy of scanning is not seriously being questioned by anyone at this time. To illustrate, even though last year's Institute of Medicine study suggested certain additional clinical trials, it did not question the basic medical importance and usefulness of scanning. Instead, the issue has focused on effective utilization and the cost consequences.

However, the total cost of CT scanning in 1977 and the cost of scanning in 1980 have been estimated to be roughly equal to the cost of medical and surgical procedures it replaces. In other words, CT scanning has not significantly changed the cost of medical diagnosis when appropriately used and has the potential to reduce costs in the future. Specifically it is estimated that the cost of CT scanning in 1977 is approximately equivalent to the conventional diagnostic procedures it replaces, in that the total cost of diagnosing of these suspected abnormalities for which CT is considered medically appropriate is estimated at approximately \$3.2 billion in 1977. And this cost could decline slightly in 1980 despite the fact that 4 million CT procedures will be done [2,500,000 or 267 percent more procedures than in 1977]. The estimated cost of diagnosing these disorders if CT were not available would be about the same—\$3 billion in both 1977 and 1980. Among key assumptions, on which the cost comparison for 1980 is based, is that by then CT will bear out its promise of substituting in part for such procedures as X-ray, pneumoencephalography, angiography, nuclear medicine, and exploratory surgery; this already is happening in many major medical centers.

It is worth emphasizing, too, that these estimates do not assign any value to certain real gains to patient care provided by CT, such as increased ease and accuracy of diagnosing, improved patient comfort, reduced risk of mortality and morbidity, and other qualitative advantages of CT scanning. Obviously, these kinds of gains, while difficult to quantify, are among the most important health care benefits that medical technology can hope to achieve.

With this kind of record, one would think that prompt introduction of a reasonable number of CT scanners, properly dispersed, would be in fact an affirmative goal of the planning process. Yet the motivating factor in much of the CT debate seems to be dealing with a runaway horse. The common belief about CT scanners is that they are being bought by the plane load, willy-nilly. On the contrary, certificates of need approvals and orders for scanners have dropped drastically.

I would like to illustrate. Industry surveys of planning agencies indicate a clear trend. For example, our information indicates that orders approximated 350 units in the first half of 1976 and 250 units in the second half. That number had dropped in the first half of

1977 to approximately 150 units and in the second half the estimate is that it will be about 90 units. In this year, 1978, in the first half we estimate the number of units will be between 50 and 70 and by the second half will have gone to the 30 or 40 range.

Finally, to talk for a moment about 1979, in the first half of 1979 it looks as though the number will further drop to the 20 to 30 range.

Contrary to popular belief, private purchases of scanners are minimal, and have not risen to fill in the decrease in CON approvals. In short, the planning process has already brought scanner placements to a crawl compared to the pace 18 months ago. In view of the efficacy and favorable cost impact of scanning, this is not simply a reaction to a problem, it is an over-reaction, spurred by fears of potential abuse which over-ran a thoughtful appraisal of both the total costs and total benefits of scanning.

The HEW guidelines proposed in September and republished recently will write this over-reaction into Federal regulations. Contrary to published reports, the January CT scanner guideline is not better from our point of view; it is worse. The effect of the numerical limits with respect to patient procedures and the new definition of patient procedure will severely curtail further dispersion of this cost-beneficial product. This is not in the interest of the best health care.

This illustration is not cited for the purpose of condemning out of hand the entire CON, HSA or guideline-writing process. Instead, it is offered to support our view that the entire planning process must from the start be affirmatively focused on encouraging the introduction of technology which is cost-effective. This requires different guidance for CON review and HSA's, as we have recommended. It requires that the planning process get its feet on the ground and develop the capacity to make sound decisions before it shoulders new responsibilities.

We appreciate the opportunity to be here this morning, and we will be pleased to answer any questions you may have.

Mr. ROGERS. Thank you very much for your suggestions, which the committee will look at carefully.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

You know, we have heard more about computerized axial tomography in the past few weeks than I have ever heard about any sort of instrument whatever. CAT scanners—I am afraid someone is going to think we are saying cat skimmers, we have skun more cats in the past few weeks than I have ever heard skun.

There are so many other things in addition to the CAT scanners that are involved.

Actually you use CAT scanners for pneumoencephalographies is that not true?

Mr. BUZZELL. Yes.

Mr. CARTER. Otherwise how would you do this if you want an encephalography?

Mr. BUZZELL. I cannot answer that question.

Mr. McCUNE. You have obviously just narrowed your options. You would have to go to surgery.



Mr. CARTER. Yes, through the base of a skull you could go and then underneath and so forth. It is a rather difficult procedure.

You use scanners for angiography. So that we know what that is, let's just explain that procedure.

Mr. McCUNE. That is injection of enhancement dye that allows better contrast in your diagnostic results.

Mr. CARTER. It shows us the size or interlining of arteries, is that correct, of blood vessels?

Mr. McCUNE. Yes.

Mr. CARTER. Instead of that, without a CAT scanner we would have to use a catheter and go in. This saves that; is that true?

Mr. McCUNE. Yes, sir. I am not a physician, but in my personal opinion I would say it would certainly be less painful.

Mr. CARTER. Did you develop the CAT scanner, the computerized axial tomographer?

Mr. McCUNE. One of our mutual companies that belongs to both organizations, EMI of England, was the principal developer of the computer axial tomographic scanner.

Mr. CARTER. It really offers a great deal of assistance in diagnosing different cases. In nuclear medicine, for instance. Furthermore, many of us are becoming a little bit afraid as time goes on that because of the injection of radioactive materials into the bloodstream, it is thought now to cause forms of cancer. This would replace that and also exploratory surgery.

What is the cost of the average scanner? Let's leave off the word "CAT". That does not sound like medicine at all.

Mr. McCUNE. An average would be difficult because there are several configurations. You have a straight head scanner, a body and head scanner or straight body scanner. For a combination system, an average figure I think you are looking at \$500,000. In the state of the art, the learning curve on head scanners, is bringing the unit cost down, they are now available in the upper \$90,000 to \$140,000. The free market always works for a downward price.

Mr. CARTER. What about a deep therapy X-ray machine, what is the cost of that?

Mr. McCUNE. Deep therapy?

Mr. CARTER. Yes; no one has mentioned that.

Mr. McCUNE. Again, as a physician you know you can get the Ford or the Cadillac.

I would say probably an average of \$250,000.

Mr. CARTER. No one has mentioned that although there are many more of them around, I think

What about a cobalt machine, what is the cost of a cobalt machine? No one has bandied that about either.

Mr. McCUNE. The Cobalt 60 machine when first introduced in the market several years ago—it is now being phased out because of new machines, but the Cobalt 60, I believe, came into the market at about \$175,000 to \$200,000.

Mr. CARTER. What about the lineal accelerator?

Mr. McCUNE. I believe you are looking at something higher, but that is due to the state of the art progress and the patient improvement.

Mr. CARTER. There are many other things besides scanners to talk about. I think we should talk about some of the other things. We have skun too many cats already.

Do you feel that a private physician with a large practice or a group of physicians who deal solely with patients who do not receive Federal largesse should be permitted to buy a scanner if they so desire?

Mr. BUZZELL. Yes.

Mr. CARTER. Or linear accelerators?

Mr. BUZZELL. Yes.

Mr. CARTER. Or a coulter machine, a blood counter?

Mr. McCUNE. Yes, sir.

Mr. CARTER. I tend to agree with you on that. I think you would agree we must use facilities as cost effectively as possible, and as long as it is not at the expense of the patient. We have to consider the patient.

Of course, this legislation, when passing this we could hurt an industry, practically destroy it. I want you to survive and flourish, but certainly I would hope it would not raise the level of health care costs all over the country.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you.

What is the exposure of radiation to the patient when one uses a CAT scanner?

Mr. McCUNE. It would be relative to the type of procedure being used.

Mr. ROGERS. A head scanner?

Mr. McCUNE. I think probably the same level as a basic skull X-ray,  $1\frac{1}{2}$  rads perhaps. Again, I am not a radiologist.

I would say you are in the same ball park as your regular X-ray equipment or less. Your earlier models were slower, but we are down to 1- and 2-second scans.

Mr. ROGERS. What about a body scanner?

Mr. McCUNE. It is hard to be specific because, it depends on the organ, the pancreas might require 4 to 6 or more slices. The slices are what is involved. It is like a firoscopic examination, you will get more rads in that procedure than in a chest X-ray. It is hard to be specific, but I think it would stand up in terms of what presently is being done or be better.

Mr. ROGERS. Have any studies been done on the effects of radiation from the scanner?

Mr. McCUNE. Yes, sir; we are working very closely with the Bureau of Radiological Health and they are working closely to see that we work for improvements and I think improvements are there.

Mr. ROGERS. Would you let us have any studies that have been done for the record?

Mr. McCUNE. I can't speak for the Bureau of Radiological Health.

Mr. ROGERS. We will contact them.

Mr. CARTER. You express this in terms of rads?

Mr. McCUNE. Yes, sir.

Mr. CARTER. I understand—I heard this from McCormack, someone from Washington—if one walks through Union Station his exposure to X-radiation there is 500 milligrams.

Thank you, Mr. Chairman.

Mr. ROGERS. That would be five-tenths of a rem?

Mr. McCUNE. Yes; your atmospheric scatter is getting quite serious.

Mr. ROGERS. What large capital expenditures in technology could you point to that truly are labor or cost saving?

Mr. BUZZELL. A major sterilization system for a hospital replacing the old enclave unit sterilizers and major laundry systems are examples.

Mr. ROGERS. Would you let us have some figures on that? I think that would be helpful.

Mr. BUZZELL. Yes, sir.

Mr. ROGERS. As I noticed, Mr. Buzzell, in your testimony you say already they have sold some 950 scanners in this country.

Mr. BUZZELL. I made reference to the approvals on a year-by-year basis.

Mr. ROGERS. In other words, they have been approved but not that many actually sold?

Mr. BUZZELL. They are either on order or in place in the aggregate.

Mr. ROGERS. Is it anticipated all the orders will be filled?

Mr. BUZZELL. I think most of them will be filled, probably all of them because they do represent certificate-of-need approvals. They have been through the planning process.

Mr. McCUNE. I think today a manufacturer would not consider he has a contract until he has the certificate-of-need approval. That is why we support the procedure.

Mr. ROGERS. Has there been any difficulty getting CAT scanners as far as certificate-of-need is concerned?

Mr. McCUNE. Yes; I think that is the point we are trying to make; that is, your planning system that is out there has certainly focused on the scanner and the approval process is a very thoughtful and very thorough process. Our point is that it is working and you can see by the data I gave you that in fact the certificate-of-need that is required, is one that goes through very careful scrutiny now, and there certainly has been difficulties on the part of individual hospitals securing scanners.

Mr. ROGERS. Has that been a supply problem or a certificate-of-need problem?

Mr. BUZZELL. First of all, the certificate-of-need process is dictating the placement of scanners into a facility. Clearly there has been lag time in the supply. I would ask Bob McCune, but I believe the demand is being met. It is more a question of thorough review by the planning people. The point we wanted to make is that your planning system in terms of this one piece of equipment, is certainly working.

Mr. McCUNE. I think that is a fair statement, as these CAT scanner guidelines are promulgated, I think the door will come down and regardless of how many sets of needs you have, there won't be any more.



Mr. ROGERS. Why, if there is a need?

Mr. McCUNE. Because the so-called utilization rates set forth by HEW cannot be practically achieved without going in some cases to double shifts in hospitals. Thereby increasing your labor intensity and the wear and tear on the equipment. Except for very high patient throughput in several large hospitals, could you achieve these kinds of levels unless you ran patients through just for the sake of numerical achievement? If you did it on a strictly medical need, a professional basis, you would not be able to achieve the kind of numbers that have been established in the guidelines for CAT scanners so the rest of the discussion becomes moot.

Mr. ROGERS. Does the company project appropriate use of the machine in its discussion or explanation of the machine?

Mr. BUZZELL. Yes. As a matter of fact, we are meeting with HEW to discuss what the levels ought to be and what the definition of a procedure should be. To say it simply, in our judgment HEW is requiring what I would describe as the ultimate utilization of the machine. If an institution in Kentucky or Florida could not quite meet that level of utilization, then they would in fact be denied the equipment. That is the debate, over the definition of a procedure and the number of procedures a facility would have to do to meet the requirements.

Mr. ROGERS. What does the company tell the facility when they sell it for so many procedures, you get so many procedures out of it, the optimum use?

Mr. McCUNE. I think to sell the equipment we accept that fact. I think there are professional people, selling this type of equipment. The type of person who could not sell used cars. They deal in a professional manner. For example in some units, they can show that 1,200 patients will be cost effective for your hospital.

Mr. ROGERS. That is what I wondered and whether HEW has related to how the company says the machine should be used?

Mr. McCUNE. We have offered many times, Mr. Chairman, to give them that kind of data. We filed 60 pages of comments. We finally, as Mr. Buzzell has said, look forward to our meeting on Monday to have this kind of exchange.

Mr. ROGERS. Are you saying a certificate of need would not be issued unless the very optimum use of the machine is accomplished?

Mr. McCUNE. The standard is minimum utilization which cannot be achieved for 98 percent of the equipment out there today.

Mr. ROGERS. Is that because of improvements in the new compared to the old?

Mr. McCUNE. Just because the hospitals don't set up to operate that kind of needed double shift or 50 or 60-hour work week. We are hopeful for improved CT use and we endorse in your title III, this granting of funds for outpatient clinics. We think those kinds of environments will be different and perhaps in time, when the facts are in, they will show that, yes, you can get achieve optimum use.

I will state for you an example. If these guidelines go into effect and we have a company that has in development a mammagraphy

scanner. The prototype still has lots of problems and it is going through a clinical development. If it is successful, they will put a mamagraphy machine on the market that will not only distinguish between cysts and tumors but determine whether a tumor is benign or malignant. What a marvelous breakthrough. You can't take the same HEW utilization rates with those kind of numbers and do mammograms. If the company is successful in developing this system, chances are they will never be able to put that kind of machine into the health care of this company.

Mr. ROGERS. I anticipate even your sales would not anticipate the same usage, would it?

Mr. BUZZELL. No.

Mr. ROGERS. I would think whoever wanted to buy it would anticipate reducing use in that condition.

Mr. BUZZELL. With due respect to HEW, I can appreciate their problem, but I would like to make this comment. I think what is out there is a partnership between the medical community, the planning agency, the manufacturer with his expertise, all of which are in the business of trying to make a sound judgment as to whether or not a unit ought to be put into their facility.

I don't think that a fairly simplistic set of guidelines, regardless of what the number is in there, can address the complexity of that problem on a nationwide basis.

I recognize the need for national guidelines. I do suggest, though, that it can't be reduced to a simple numerical expression. Whether it is 2,500 or 4,000, it simply cannot be done.

One of the issues, Mr. Chairman, is what represents a scanner, how are procedures counted? Is it the sum of pictures taken or the patient episodes involved. These are the kinds of questions the national guidelines will address.

Mr. CARTER. If you will yield on that, Mr. Chairman, I don't want to belabor the subject but this is quite a machine and I am sure you have seen them operate and outline a brain tumor and such things as that.

As I said before, we want to see enough scanners but not too many, and certainly we don't want—I personally would not want to hurt your industry, neither would I want to see every doctor's office have one—they couldn't use them anyway.

Mr. BUZZELL. If I could make one point. It appears there is somewhere in the order of a thousand or 1,100 of these machines out there now, and they appear to be properly distributed. There may well ought to be somewhere around 2,000, to put it into context. What we are a little concerned with is they are going to stop at the 1,000 or 1,100 level. That is what we are referring to today.

Mr. ROGERS. You realize, of course, the guidelines that have been reissued are simply guidelines? The HSA may make recommendations that don't necessarily follow those guidelines if there is a need in their own area.

Mr. BUZZELL. They take on the weight of Federal regulations.

Mr. ROGERS. No, I think when they were first issued this was true but they are now being reissued with another 30 days for comments. We have reached an understanding with the Department that HSA's



have the final judgment on the applying of guidelines in their own areas and the committee will follow that up.

Mr. BUZZELL. I am relieved to hear that expression of intent because I think it is important for HEW to understand.

Mr. ROGERS. Yes, I think that is true.

So the industry then feels about 2,000 is about what is right?

Mr. BUZZELL. I would not want to be held to that, but if you figure that there ought to be one for roughly every 100,000 citizens, that is what the number would be.

Mr. McCUNE. If the machine I described came into being, you would want it to replace some of the present mamography equipment.

Mr. ROGERS. They would be substituted?

Mr. McCUNE. Mamography machines have a limited purpose and could not be substituted for other types of equipment.

Mr. ROGERS. Your head scanner was substituted for X-ray, was it not? It should be but isn't yet.

Mr. McCUNE. I think as you replace all the equipment it is. That is not being considered when you look at these numbers.

Mr. ROGERS. I am not sure it really is being substituted. I think it is cumulative. Too often we are finding not only does the patient go through X-rays on top of that they then go through the scanner. This is a concern of the committee that in bringing so much new technology before the medical profession has confidence in it or is willing to use it, maybe we are doing it too rapidly.

Mr. McCUNE. I think this happens in any new thing. Even the professionals always go through a learning procedure.

Mr. ROGERS. I would agree and I am not sure until it has been proven out clinically and interpretations made so that they have confidence in the interpretation of the results, it should be flooding the market.

Mr. McCUNE. The jury is coming in now. The facts are coming in. They have been out there. We know, for example, they used to do a basic scan and if they could not get the kind of information they needed, then they would go to a contrast or enhancement series with some additional pain. If they go directly to the enhancement procedure now and skip the first scan, they get the insured results only at the expense of some pain.

Mr. ROGERS. What I am concerned with is they run you through the X-ray tests all the way and then put you through the scanner. There is a lot of that.

Mr. McCUNE. I know the concern.

Mr. BUZZELL. They don't hurt.

Mr. ROGERS. Not in the first year, but maybe the X-ray may after that.

Thank you for being here. Your testimony has been helpful and we will be in touch with you.

The committee stands in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please. The members are on their way. I think we will get started.

Our next witness will be Dr. James R. Kimmey, who is director of the Midwest Center for Health Planning.

Dr. Kimmey, we are pleased to have you here.

Your statement will be made a part of the record, and you may proceed as you desire.

# **STATEMENT OF JAMES R. KIMMEY, M.D., ON BEHALF OF REGIONAL CENTERS FOR HEALTH PLANNING**

Dr. KIMMEY. Mr. Chairman, I appreciate having the statement put in the record [see p. 1075]. I would like to take a couple of minutes to highlight it.

Section 1534 of Public Law 93-641 authorized the Secretary to create, by grant or contract at least five regional technical centers for health planning and development. The Secretary decided to utilize the contract mechanisms and to contract for establishment of a center for health planning in each of DHEW's 10 regions. Five such centers have been operating for 24 months and five have been operating for 18 months. The contracts have limited the technical assistance centers to three functions: training, consultation, and the development of generic materials—films, booklets and so forth—that would be of assistance in training the staff and board of agencies in the regions we serve. The report I submitted as part of the record summarizes the experience of the 10 centers through December 31, 1977.

I would just like to highlight a few things in the report. The 10 centers presented 241 courses during that period of time—

Mr. ROGERS. About what is the extent of that course?

Dr. KIMMEY. The course ranged from 1 to 3 days. There would occasionally be a 4 day course. We presented 241 courses, training 8,469 participants. We conducted, among us, 960 major consultations, involving a specific task order and onsite activity. In addition, the 10 centers offered 6,755 minor consultations. These are contacts between the center and the client agencies, such as telephone contacts, literature searches and so forth. That turns out to be some 28 contacts between each client agency and their center during that 2 year period. The centers collectively have produced about 80 items of generic material, glossaries and so forth, during that period of time.

A couple of other points in the report are of more than passing interest.

One is the target audience figures for the training courses that were presented by the ten centers. The HSA staffs were the largest consumers of training, followed by HSA boards, State staff, and the statewide health coordinating council people. I wanted to mention that to explain the reasons State participation looks a little low. In the case of the coordinating councils, they have been slow to get organized. Looking at gross figures, their figures appear artificially low. The other factor, of course, is that we have 4 times as many HSA's as the State agencies.

We do know that 92 percent of the HSA's in the country and 87 percent of the State agencies have participated in center activities over the 2 year period. We have had fairly heavy participation from the client agencies of the centers.

The nature of assistance people are looking for is significant. The three areas most frequently involved training, consultation, and generic materials were the same. Those are the plan development, which are the skills that are needed in order to develop the health systems plans, agency organization and management, and project review, the cost-containment activities of the agencies.

I think one other important aspect of the center program is the high degree of cooperation achieved among these 10 independent contractors through bimonthly meetings, and exchanging materials on a continuing basis. We have exchanged staff and consultant lists, and we have used each others staff and consultants in various projects. We think this is a basic element of the project's strategy, and one that has led to less duplication of effort than might have been the case had we not had it.

I would also like to mention briefly a previous study of the centers that has been done by the General Accounting Office in four HEW regions. Only a draft of the report has been seen by the centers. We find it does make constructive suggestions concerning center programs. Both those suggestions, however, and the criticisms that have been brought up in this report need to be examined from the perspective of the timing of the study. The GAO study was undertaken in the fall of 1976. At that time, two of the centers that were studied had been in business since July 1 of 1976, and the other two centers had been in business for 9 or 10 months.

The report we have submitted today covers a full 2 years of operation of the centers. I would hope that the committee, in looking at the GAO report, will also look at the data on the full 2 years of effort. I think it is fairly impressive in terms of the amount of activity that has been conducted by the centers in support of health planning and development.

Finally, although H.R. 10460 would continue the present model of independent centers, there are those that question the effectiveness and appropriateness of this approach. Two alternatives have been discussed—one is that these funds be broken up and given to the client agencies, and the second is that the authority and the funding be given to HEW regional offices, and the HEW staff themselves would take on the technical assistance and training function. The former approach, redistribution, I think, has a number of problems. Probably the most difficult one is that one of the key elements in the centers' program has been bringing client agencies together in a training setting so they can exchange ideas of what works in various settings with one another. You lose that if you use decentralized funding mechanisms. In region V, if you divided the money, each agency would have \$8,700 a year, and that is not enough to put on full-time training staff or to procure consultant services from commercial consulting firms. We believe there is value in development of a long-term relationship between the center, as the consultant, and the client agency as the consumer of consultation, so we know over time exactly what each agency status is, and exactly what kinds of things they are most likely to need.

The Regional Office approach also has some built in disadvantages compared to the independent center approach. First, it creates a



situation in which all of the technical assistance for health planning and development agencies flows from the same organization which ultimately has to approve and fund their projects. This can only lead to parochialism and stifle the innovative approaches we are seeing now in various agencies around the country, all moving toward the same goal. Second, the Federal procurement system is so complex that it works against fast response consultation. This has been one of the major strengths of the centers' programs, being able to get the right consultants for the client's problem as quickly as possible. Finally, the Federal problems with grade levels and with personnel allocations and so forth, would make it difficult for the regional offices to attract and retain the special staff capabilities we feel the independent centers have attracted and are retaining to help us do our job well.

We feel that the independent centers have demonstrated their ability to deliver quality, training, consultation, and technical assistance. We do feel we could do more if we were allowed to.

Section 1534 envisioned the centers for health planning with a much broader mandate. This committee, in putting that language together, suggested the centers do research and undertake the development of new techniques, and do comparative analyses of various techniques for planning as well as providing training and consultation assistance. The Department, in setting up contracts, has limited us to training, consultation and generic materials development. We feel the centers are accomplishing that mission, and we would like to have the full intent of section 1534 implemented and give us an opportunity to become more involved in research and developmental work.

That is a summary of what I have to say, Mr. Chairman.

[Testimony resumes on p. 1099.]

[Dr. Kimmey's prepared statement and attachment follow:]

STATEMENT OF  
JAMES R. KIMMEY, M.D., DIRECTOR  
MIDWEST CENTER FOR HEALTH PLANNING  
MADISON, WISCONSIN

ON BEHALF OF  
THE TEN REGIONAL  
CENTERS FOR HEALTH PLANNING  
CREATED UNDER S. 1534 OF THE  
PUBLIC HEALTH SERVICE ACT, AS AMENDED

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE--

I am Dr. James R. Kimmey, Director of the Midwest Center for Health Planning of Madison, Wisconsin. I am appearing today on behalf of the ten regional Centers for Health Planning established under provisions of S. 1534 of the Public Health Service Act, as amended. These ten Centers have contracted with the Department of Health, Education and Welfare to provide technical assistance, in the form of training, consultation and generic materials, to health planning and development agencies created under Title XV of the Public Health Service Act.

Although the Centers have no national organization, we sought the opportunity to appear today to review for the committee the progress made by the Centers for Health Planning, the authority for which would be extended under H.R. 10640. We feel the Centers collectively can be proud of the accomplishments of the past two years in the provision of services to our agency clients. Indeed, no other components created under the programs authorized by P.L. 93-641 can, collectively, point to so much progress toward meeting the goals set under P.L. 93-641.

As was indicated, there are now ten regional Centers for Health Planning, one in each of DHEW's ten Regions. Six of these Centers are non-profit private corporations, two are located in universities, and two are housed in consortia of universities. All ten are supported by contracts from the Health Resources Administration, DHEW. As specified in the law, each Center has a full-time Executive Director and a multi-disciplinary staff. Each Center has, as its exclusive clientele under its contract, the HSAs, SHPDAs and SHCCs in its Region. Each conducts a variety of training



and consultation activities which are coordinated through the HEW Regional Office serving the same area. This statement is accompanied by an activity report covering all ten Centers for the two year period ending December 31, 1977. For five of the Centers, which began operations on January 1, 1976, this report covers twenty-four months of activity. For the other five Centers, which began their programs on July 1, 1976, eighteen months of effort is represented in the report. The report was prepared by the Centers as an independent effort to pull together, in one place, a variety of data and information on their operations. If it is acceptable, I would like to summarize certain of the data which is included in the report, and ask you to consider placing the entire report in the record.

One of the major technical assistance functions of each of the ten Centers is the development, conduct and evaluation of training courses for staff and board members of HSAs, for SHPDA staff and for SHCC members. During the reporting period ending December 31, 1977, the ten Centers for Health Planning:

- Presented a total of 241 training courses, which were attended by 8,469 participants. The distribution of these participants is of some interest, with 47% drawn from HSA staff, 24% from HSA boards, 12% from state agency staff, and 5% from among the members of the SHCCs. Lest the latter figure give the appearance that the Center's are serving state level clients less, it should be remembered that these figures represent total attendance at all courses. Since there are 205 HSAs and only 56 states and similar jurisdictions, the state percentage appears less. Also, a number of SHCCs were very slow in organizing, and this is reflected in these figures.

- From the standpoint of course content, nearly half the courses had content related to plan development, while 37% dealt with review activities, reflecting the high priority placed on project review as a cost-containment mechanism. Thirty-four percent of the courses dealt with issues of agency organization and management, a critical interest of the clients during the formative period of the health planning and development agencies.

The second major technical assistance modality utilized by the ten Centers is consultation. Consultation encompasses a variety of problem-specific activities which bring the Center staff and consultants together with one or more client agencies. During the two years ending December 31, 1977, the Centers:

- Conducted a total of 930 major consultations with client agencies, an average of 3.4 major consultations per health planning and development agency client. Of these, 77% were consultations to HSAs and 23% were consultations with state agencies or SHCCs.

- Conducted a total of 6,755 short-term consultations (including telephone consultations, literature searches, in-office reviews of documents, etc.), an average of 25 contacts per health planning and development client agency on a nationwide basis. Of these short-term consultations, 73% went to HSAs and 27% to state agencies and SHCCs.

- In the case of HSA consultation, the greatest demand for assistance was in the plan development field (34%) followed by agency organization and management topics (24%) and review activities (14%).

- State agency consultations were most frequently in the same three content areas, although plan development assistance was requested by the state agencies twice as often as assistance in either of the other categories.

The third element of technical assistance provided by the Center under the contract is the development of generic materials--booklets, guides, texts, audio-visual materials--which can be used by many client agencies. During the reporting period ending December 31, 1977, the ten Centers:

- Produced a total of 80 generic documents, films and video tapes.

- Of these generics, 54% deal with issues relating to agency organization and management, 40% deal with issues relating to plan development and 36% deal with issues related to project review.

More detailed information on each of these activity areas can be found in the attached report. The major point of emphasis here is that the Centers for Health Planning have been very productive, and that the client agencies have, on the average, received a high volume of direct service that might not have been available in the absence of the Centers.

It is also significant to note that the Centers for Health Planning have developed a high level of inter-regional exchange and cooperation. The Centers meet as a group on a bi-monthly basis, and have numerous continuing exchanges of information and materials. For example, course announcements, syllabi, and materials are circulated among the Centers on a regular basis, as are schedules of courses and the Center's newsletters. During the reporting period ending December 31, 1977, the Centers:

- Exchanged Center-developed generic materials, with each Center utilizing such materials from an average of five other Centers.
- Jointly sponsored training activities, with eight of the ten Centers holding at least one jointly sponsored activity with another Center during the period, and six holding two or more such joint sessions.

This unusual degree of cooperative interchange between independent contractors who are spread widely across the nation was a part of the basic concept of Centers formulated by the Department at the beginning of the program. Departmental efforts have facilitated this aspect of Center operations, promoting interchange and decreasing unnecessary duplication of effort in the development of courses and the production of various generic materials. In addition, all of the Centers have coordinated their training and consultation efforts in data with the Applied Statistic Training Institute, and their information efforts with the National Technical Information Service.

Lest this report suggest that the Centers for Health Planning is the least troubled and most effective program ever created under the auspices of the Department of Health, Education and Welfare, it is important to point out that there are problems. One of the problem areas that has plagued a

few but not the majority of Centers is the problem of role identification between the Center and the HEW Regional Office. This committee took cognescence of the problem in laying out suggested ground rules for the Center-Regional Office relationship as a part of the report accompanying P.L. 95-83. There have been problems with the contract financing mechanism, and the stringent management rules which HEW attaches to contracts, which are not always compatible with a flexible and adaptable technical assistance program. A Center has to be ready to respond quickly to rapid shifts in federal implementation policy and to new federal initiatives like the National Guidelines for Health Planning and Development. The sluggish rate of implementation of P.L. 93-641 at the federal level has also had an effect on the Centers. It is extremely difficult to train individuals to perform tasks based in large part on federal regulation and guidelines in the absence of those regulations and guidelines. None of these problems, however, has been serious enough to compromise the overall effectiveness of the Center's program. The Centers have produced in spite of these barriers.

It is also important to mention a previous study of the Centers for Health Planning performed by the General Accounting Office as a part of a larger study of activities in four HEW Regions. Although the written report of the GAO study, which has appeared in draft, makes some constructive suggestions for improving the Centers program, both those suggestions, and some of the negative impressions gained by GAO in its audit, must be viewed in perspective. The GAO studies were undertaken during the fall of 1976. In two of the regions which they visited, the Centers had been funded on July 1, 1976. In the other two, the Centers had been in operation for approximately 9 months. Further, the client agencies sampled by GAO were also at an early stage of development, and had not yet identified their technical assistance needs nor the Centers' role in meeting those needs. Thus the study and its conclusions were based on information available at a very early point in the history of this program. We would urge the members of this committee to view the suggestions and criticisms of the GAO staff against that time perspective, and against the perspective of the data in the attached report.

We also want to lay before the Committee our views concerning the appropriateness of the present approach to provision of technical assistance services through Centers organizationally independent of the Federal government and of the client agencies themselves. We are aware that alternatives to the current approach have been proposed, and feel that each alternative has shortcomings which would make it a less effective approach to provision of these services to health planning and development agencies.

One school of thought suggests that the resources currently channeled through the Centers to the client agencies be divided among those agencies. Each HSA and SHPDA would develop its own technical assistance strategy and finance it with the additional monies made available. Among the shortcomings of this approach would be the following:

- (1) A key factor in the current approach is the promotion of interchange of ideas among client agencies in the training or consultation setting, one which would be lost were the clients to "go it alone" in procuring their own technical assistance.
- (2) The amount of money made available to a given HSA or SHPDA would be relatively small, too small to hire additional staff to manage a technical assistance program, or to procure any significant amount of outside consultative assistance. In Region V, for example, the Center contract provides an average of \$8,750 per client agency per year, an amount which, if allocated to the client agencies, would provide little leverage for a technical assistance program.
- (3) Utilization of a single source, such as the Centers, for a large share of training and technical assistance provides a consistency of approach over time, and a shared base of understanding between Center and client, difficult or impossible to achieve under a totally decentralized model.



A second school of thought suggests that the technical assistance functions currently provided by the Centers could be provided equally effectively by allocating the monies and authority to the Regional Offices of the Department. This too, we believe, is an approach with several potential weaknesses. They include:

- (1) An element of conflict of interest is implicit if the same organization is responsible for both providing all guidance in program development and for deciding whether or not the program is to be accepted and funded. The current system supports innovation and appropriate variation among health planning and development agencies in their approaches to their many functions. Were the funding agency to become the source of technical assistance as well, experience suggests a shift toward a single acceptable model would follow. The clients feel more open in discussing their problems and possible solutions with individuals who do not control their pursestrings.
- (2) The flexibility of the present approach in responding rapidly to specific client needs with the most appropriate available assistance might be compromised. Although the Centers operate within Federal guidelines and contract requirements concerning consultant fee schedules and subcontracting, the procedural constraints present inside the Federal system are more restrictive, and make it more difficult for a Federal agency to procure personal services on a short-term or short deadline.
- (3) The restrictions of the Federal system on position control and grade levels, and the vicissitudes of Federal centralization-decentralization policy, would make it difficult for a Regional Office to attract and retain the special staff capabilities which have been developed by the independent centers.

In summary, the Centers for Health Planning approach has demonstrated it is viable, effective, and popular with the client agencies. Despite isolated instances of conflict between Centers and Regional Offices, or contract difficulties, or occasional client dissatisfaction, an enviable record of achievement has been compiled to date.

Finally, we do feel that the Centers are capable of carrying out a much broader scope of activity than has been permitted by the Department under the current series of contracts. The Congressional mandate for the Centers included much more than training, consultation and development of the generic materials. The Centers were envisioned by the Congress as entities with the capability to undertake research, and the development of new methodologies and techniques for planning, as well as being providers of direct technical assistance. The Department has chosen to limit that mission. We feel that we have demonstrated over the past two years that the concept of independent Centers to support activities in health planning and development was a wise and effective one. We would like to see increased flexibility on the part of the Department in defining the Centers' functions, and an expanded commitment to carrying out fully the intent of s. 1534 as enacted by the Congress, and as it would be renewed under provisions of H.R. 10460. We do not feel that contractual provisions, which would allow the Centers to devote something approaching 2% of the total budget to development as incorporated in the Department's latest RFPs for continuation of the Centers activity, is an adequate response, nor is it commensurate with the Centers' abilities to perform expanded functions.



Public Law 93-641  
93rd Congress, S. 2994  
January 4, 1975

*An Act*

88 STAT. 222

To amend the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resources development programs, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

SHORT TITLE; TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "National Health Planning and Resources Development Act of 1974".

TABLE OF CONTENTS

- Sec. 1. Short title; table of contents.  
Sec. 2. Findings and purpose.  
Sec. 3. Revision of health planning programs under the Public Health Service Act.

TITLE XV—NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT

PART A—NATIONAL GUIDANCE

"Sec. 1501. National guidance."

"Sec. 1502. National guidance."

National  
Health  
Planning and  
Resources  
Development  
Act of 1974

**ASSISTING TRANSITION**

**Report on the Activities of the Ten Centers  
for Health Planning, 1976-77**

## ASSISTING TRANSITION

Report on the Activities of the Ten Centers  
for Health Planning, 1976-1977

"The proposed legislation contains a variety of provisions intended to improve the health planning and resources development processes throughout the country, and to provide assistance and support to the planning agencies developed under the bill in the performance of their activities. Of these measures, the most important is the requirement that the Secretary provide funding for the establishment of at least five new centers which will provide technical and consulting assistance to HSAs and state agencies"... House Report accompanying P.L. 93-641.

The preceding quotation, referring to the Centers for Health Planning authorized under Section 1534 of P.L. 93-641, embodied high expectations for this new approach to training and technical assistance for health systems agencies, state health planning and development agencies, and state-wide health coordinating councils.

On the basis of the authority in Section 1534, the Secretary of Health, Education and Welfare has supported, through contract, the establishment of ten regional Centers for Health Planning, one in each HEW region. These Centers have assumed specific contractual responsibilities to provide training, consultative services, and technical assistance materials for the health planning and development agencies in their respective regions.

This report summarizes the activities of the ten Centers for Health Planning during the period from January 1, 1976, when the first five Centers were established, through December 31, 1977. The information contained in this report represents 24 months of experience for each of five technical assistance Centers, established on January 1, 1976, and 18 months of experience for five Centers established, following a second round of procurements, on July 1, 1976.

The data and information summarized in this report was collected from all ten Centers during December 1977 and January 1978. More specific information concerning the activities of any of the Centers can be obtained from the Director of the individual Center or from the Bi-monthly Reports filed by the Centers under their contract with the Department of Health, Education and Welfare.

## WHAT CENTERS ARE

Public Law 93-641, the National Health Planning and Resources Development Act of 1974, was signed into law on January 4, 1975. This important Congressional initiative extensively revised federally-assisted mechanisms for health planning and resources development in the United States. Under provisions of the Act, a number of pre-existing federally-supported programs were eliminated, and their functions merged in a new set of entities at the area and state levels. The new structural components--health systems agencies (HSAs), state health planning and development agencies (SHPDAs),

and statewide health coordinating councils (SHCCs) were assigned broad responsibilities for planning for the health system, allocating financial and other resources within that system, and developing and carrying out regulatory activities affecting the system. Taken together, these functions were intended to lead to improvement in health status and health services in the United States, and to lay the groundwork for future efforts to improve the system for financing health care services.

The Congress recognized that the task of restructuring the health planning and resources development system would require the development and dissemination of new techniques for use by the new agencies. Further, it recognized that much that was learned under previous planning and development efforts would need to be translated and communicated within the new framework. In order to meet these needs, the Congress included extensive provision for various kinds of technical assistance designed to support the efforts of the planning agencies on the firing line. Under Section 1514 of the Act, the Secretary of Health, Education and Welfare was directed to provide technical and non-financial assistance to organizations attempting to become designated as health systems agencies. Under Section 1533 of the Act, the Secretary was directed to provide assistance to the HSAs, SHPDAs, and SHCCs in carrying out their functions, including technical materials appropriate for use in health planning. Under Section 1534 of the Act, the Congress directed that centers for "multi-disciplinary health planning and development assistance" be created to assist the Secretary in carrying out the purposes of the Act through technical and consulting assistance to the HSAs, SHPDAs and SHCCs. Based on these three portions of the Act, technical assistance activities have been mounted by the Department utilizing its own staff, a variety of consulting firms who have prepared specific analyses and technical materials, and ten contractors who have established Centers for Health Planning, one in each HEW region.

The idea of a series of centers, organizationally independent from both the federal government and the operating health planning and development agencies which form their client group, first emerged in the House of Representatives. Earlier federal health planning legislation had included grant and contract funds for basic and continuing education of health planners. The concept of the Centers for Health Planning as it emerged in the final legislation was quite different from these previous efforts. The Congress conceived of a more focused technical assistance program dealing exclusively with the needs of the health planning and development agencies created under the Act. Further, the centers were seen as conducting research, studies and analyses of health planning and resources development, and developing health planning approaches, methodologies, policies and standards.

In translating this legislative concept into a contractual document, the Department of Health, Education and Welfare focused the efforts of the Centers even further. In making funds available under 1534, the Department limited the Centers' supported activities to training, consultation, and the production of generic materials. The Department further required that the activities supported under the Section 1534 contracts be made available exclusively to HSA staff and board members, SHPDA staff, and SHCC members. Thus, the programs actually established and operating under Section 1534 authority are more limited than those authorized by the Congress.



The policies developed by the Department for carrying out the intent of Section 1534 are significant to a basic understanding of the way the Centers program has evolved. The Department decided that the program should support one Center in each of HEW's ten regions. A competitive procurement for establishment of technical assistance centers was undertaken in late 1975. On the basis of the initial procurement, five contracts were negotiated and Centers were established in HEW Regions I, II, III, IV, and VI on January 1, 1976. A second procurement in the spring of 1976 led to the establishment of Centers in the remaining five regions on July 1, 1976. The auspices and locations of the ten Centers for Health Planning appear in Figure I:

FIGURE I

## CENTERS FOR HEALTH PLANNING

<u>REGIONS AND STATES</u>	<u>CENTER FOR HEALTH PLANNING</u>
REGION I (Boston) Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Boston University Center for Health Planning 53 Bay State Road, 4th Floor Boston, Massachusetts 02215
REGION II (New York) New York, New Jersey, Puerto Rico, Virgin Island	Alpha Center for Health Planning, Inc. 1010 James Street Syracuse, New York 13203
REGION III (Philadelphia) Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia	Health Planning Research Services, Inc. Center for Health Planning 550 Pinetown Road Fort Washington, PA 19034
REGION IV (Atlanta) Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Health Planning/Development Center, Inc. Center for Health Planning Healy Building, Suite 1010 57 Forsyth Street, N.W. Atlanta, Georgia 30303
REGION V (Chicago) Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Midwest Center for Health Planning, Inc. One South Park Street, Room 535 Madison, Wisconsin 53715
REGION VI (Dallas) Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Southwest Center for Urban Research Center for Health Planning 1200 Southmore Houston, Texas 77004

REGIONS AND STATES

REGION VII (Kansas City)  
Iowa, Kansas, Missouri,  
Nebraska

REGION VIII (Denver)  
Colorado, Montana, North  
Dakota, South Dakota,  
Utah, Wyoming

REGION IX (San Francisco)  
Arizona, California, Hawaii,  
Nevada, Guam, Trust Territory  
of Pacific Island, American  
Samoa

REGION X (Seattle)  
Alaska, Idaho, Oregon,  
Washington

CENTER FOR HEALTH PLANNING

Region VII Center for  
Health Planning  
104 Lewis Hall  
Columbia, Missouri 65201

PACT Health Planning Center  
for Region VIII  
90 Madison Street, Suite 604  
Denver, Colorado 80206

Western Center for Health  
Planning  
693 Sutter Street, Suite 408  
San Francisco, California 94102

TAC/X Center for Health  
Planning  
100 West State Street  
Boise, Idaho 83702

HOW CENTERS ARE ORGANIZED

Despite the fact that all ten Centers were developed on the basis of essentially the same set of contract specifications, there is wide variation in some aspects of their organization. Two of the Centers are university-based, two are based in consortia of universities, and six are private non-profit corporations. Internal organization also varies from Center to Center, with some Centers organizing their staff on a geographic basis while others organize according to a functional classification of Center tasks.

Under terms of the contract, each Center was required to establish a Advisory Board representative of the client agencies and states within the region it serves. The Advisory Board is intended to provide the Center with client agency perceptions of needs and priorities, of appropriate means to meet those needs, and feedback to assist the center in evaluating its activities and making necessary adjustments.

The Advisory Board provides a direct communications link between the Center and its various client agencies in the field. The Board can indicate proper directions for content of both training courses and consultations. The Board can convey reactions from the field to various Center activities.

The average size of the Advisory Board is twelve members, with a range from nine to 15. Of the 120 individuals who serve on the Advisory Boards of the ten Centers, 41 (34%) are staff of health systems agencies, 33 (27.5%) are staff members of state health planning and development agencies, and 42 (35%) are members of HSA boards or statewide health coordinating councils or both. The remaining four individuals who serve on center advisory boards are representatives of institutions or organizations cooperating in the Center's activities. Ninety-five (79%) of the members of the Advisory Boards are male and 25 (21%) are female. Ten percent of the individuals serving in this capacity are members of minority groups.

## HOW CENTERS OPERATE

Some understanding of how the Centers operate in provision of technical assistance to the client agencies is necessary to a thorough understanding of this program. As was indicated earlier, the Centers are funded under cost-reimbursement contracts from the Department. The contract sets a minimum number of courses and person-years of consultation which must be provided over a two year period. These activity levels reflect regional variations in the number of client agencies.

Each training course, major consultation, and major generic document must be approved in advance by a Regional Project Officer in the Regional Office of HEW for the region served by the Center. The Center prepares a task order covering each major activity and submits to the Regional Office. The task orders are also forwarded to the Central Office of the program for information and for comments.

The existence of the task order mechanism means that the activity levels reflected in this report and the emphasis on various performance standards categories in the training and technical assistance programs of the Centers have been approved by the Federal government on a case-by-case basis and reflect a federal perception of the importance of the specific activity within a region.

Another aspect of Center operations which is established under the contract is evaluation of technical assistance activities. Each major activity is subject to a post-evaluation following a protocol developed by the Center--in accord with provisions of the contract--and approved by the Regional Project Officer. These evaluations are provided to the Regional Project Officer and Central Office Associate Project Officer following each major technical assistance activity. Thus the Department is deeply involved in the programming of an individual Center through the review and approval/disapproval of task orders, and has evaluative materials relating to the Center available on a continuing basis.

## HOW CENTERS ARE STAFFED

Just as organization of the Centers varies from region to region, so does staffing. The size of a Center staff is affected by two variables--the size of the region and the Center's approach to providing its services. The ten Centers have a total of 86 full-time staff and an additional 12 part-time staff. Sixty-seven of the staff members are classified as professional staff and the remainder as support staff. Of the Centers' professional staff, 23% have doctorates, and 48% have master degrees in health planning or related fields.

The staff members of the ten Centers for Health Planning come from a variety of backgrounds. Forty-two percent of the staff members bring experience with areawide comprehensive health planning agencies to the Center. Eighteen percent have previously worked with state health planning agencies and 15% with Regional Medical Programs. Sixteen percent have experience working in health institutions and 15% with consulting organizations. In the educational field, 31% have experience in graduate level university teaching and 24% in the teaching of undergraduate courses in universities and colleges.

The Congress was concerned that the staff of a Center represent a variety of disciplines. A review of the specialties of staff members in the ten Centers for Health Planning shows that the most common specialties are health planning, agency management, data and statistics, health economics, and education. Other areas heavily represented in Center staffing include community organization and development, mental health planning, and public relations. Each of the ten Centers have at least six of these eight specialties represented on staff. In addition, more than a dozen other specialties, such as urban planning, survey research, policy analysis and capital finance, are present on staff in one or more of the ten Centers.

#### CONSULTANT USE BY CENTERS

One of the strengths of the independent Center approach is the relative freedom accorded such Centers in identifying and utilizing consultants other than Center staff. Consultants are used as faculty for training courses, to prepare background materials and generic documents, and for direct consultative services with client agencies. The ten Centers have made extensive use of such outside consultants in carrying out their program of activities. During the period covered in this report, 823 consultants were utilized by the ten Centers, 50% as training faculty and the remainder in direct consultation and preparation of generic materials.

The use of outside consultants provides a Center with an opportunity to tap a variety of potential resources both within its region and from other parts of the country. The relative freedom accorded an independent Center in seeking out consultative assistance is indicated in the background of the consultants utilized by the ten Centers during this reporting period. Nearly three quarters of the consultants used were drawn from three categories of individuals--university faculty members, staff members of HSAs/SHPDAs, and free-lance professional consultants. During the period covered by this report, the ten Centers' major source of consultative assistance were university faculty members (26%) and HSA/SHPDA staff (26%). Free-lance consultants (18%) and commercial consulting firms (11%) constituted the third and fourth largest group, with the remainder of the consultants being drawn from the other categories.

#### THE TRAINING MISSION

Under the contract for services from the Department, each Center is required to carry out a minimum number of training courses directed at various target audiences within their client group each year. Each course is designed by, or for, the Center, and is based on perceptions of client agency needs gained from the Advisory Board, from surveys of client agencies, and from other ongoing contacts between the Center and the client agencies. The Center's training activities are tailored to the special needs and circumstances of a variety of audiences. Usually, courses are targeted to specific components of the client agency audience, such as HSA staff, consumer board members, SHPDA staff, or SHCC members. Other courses are broader in their orientation and touch on the interests of more than one of these groups.



Each Center offers courses in a variety of locations throughout its region. It is characteristic of the Centers program to decentralize training activities to bring them closer to the various client groups served.

Each Center is responsible for developing a curriculum, preparing materials, and securing faculty for its course offerings. The Center also manages the course, providing for registration, housing, and evaluation.

The Centers use a wide variety of training techniques in carrying out their responsibilities. The particular approach used in a given training course varies with the audience, the objectives of the course, and the subject matter being covered. Centers use traditional lecture/discussion approaches, workshops, seminars, retreats, and simulations in bringing the latest policy and technical information concerning health planning to the client agencies.

During the two year period from January 1, 1976 through December 31, 1977, the ten Centers presented a total of 241 training courses for their client agencies. The training courses varied in length from one to four days. The number of attendees at a single course varied from six individuals for a small intensive seminar to 190 attendees at a large lecture/discussion course. During the same period, a total 8,469 participants were trained, an average of 35 participants per course. Of the total participants, 3,955 (46.7%) were HSA staff members, 2,004 (23.7%) were HSA board members, 1,008 (11.9%) were state agency staff, and 412 (4.9%) were classified as SHCC members. An additional 1,090 attendees, representing 12.8% of the total, were classified as "other". SHCC attendance appears low. It is important to remember, however, that many people who classified themselves as HSA board members at the time of registration in the course are also members of a SHCC. The SHCC attendance figure represents, for the most part, attendance at specific SHCC-oriented courses presented by various centers. Attendance data by category of attendee is summarized in Table I on page 8.

The courses presented by the Centers were also analyzed according to the seven performance standard categories established by the Department for HSAs and SHPDAs. These performance standard categories are set out as expectations on the part of the Department of a satisfactorily operating health planning and development agency. A given course offering from a center may deal with more than one of the categories of performance standard. Table II on page 9 summarizes the training experience of the ten centers during the reporting period from the perspective of the performance standards covered. As might be expected during a period when the planning and development agencies were beginning their programs, and developing their initial health systems plans and annual implementation plans, the most common course content was in the area of plan development (48.5% of courses). The second most common area, plan implementation/review (36.9%) reflects the high priority placed on project review activities, with their potential for cost containment. The third most common area was agency organization and management (33.6%), an area of particular interest to the health planning and development agencies during the start-up phase of their activities.

The variation in emphasis from region to region points up the variation in client agency needs, as identified through the Advisory Board and client contacts, and as accepted by the Regional Office through approval of task orders for the courses.



TABLE I

Course Attendance by Category of Participants,  
Ten Centers, January 1, 1976 - December 31, 1977

Regional Center	Percent of Attendees, All Courses, Classified as				
	HSA Staff	HSA Board	SHPDA Staff	SHCC Members	Other
I	32%	32%	12%	5%	19%
II	53%	25%	7%	3%	12%
III	44%	42%	13%	1%	--
IV	53%	17%	10%	5%	15%
V	56%	17%	13%	6%	8%
VI	45%	21%	17%	16%	1%
VII	72%	7%	14%	--	7%
VIII	32%	25%	20%	4%	19%
IX	40%	28%	9%	1%	22%
X	<u>37%</u>	<u>35%</u>	<u>7%</u>	<u>4%</u>	<u>17%</u>
ALL CENTERS	46%	24%	12%	5%	13%

#### THE CONSULTATION MISSION

The second major technical assistance element in the centers' program is consultation to individual client agencies or groups of client agencies. Consultation takes many forms. Whether it is as simple as a telephone conversation with an individual who can answer a specific question, or refer the caller to a resource which clarifies a point, or as complex as a multi-disciplinary in-depth study of care patterns in area, consultation is the provision of problem-specific expertise. The Centers for Health Planning have provided a new independent source of consultative services to the health planning and development agencies created under P.L. 93-641. Under provisions of the contract supporting this activity, each of the ten Centers was required to develop a Statement on Consultation in conjunction with its Advisory Board. This document sets forth the Centers' general approach to its consultative mission and explores priority areas for provision of such services within the region served. Although the Statements on Consultation vary from Center to Center, there are some general themes which extend through the approaches of all ten. The consultation activities of the Center are generally conceived as closely linked to the Center's training and generic materials missions. All Centers stress the importance of consultant follow-up, both as a means of identifying the need for addi-

TABLE II  
Training Topics by Performance Standards,  
Ten Centers, January 1, 1976 - December 31, 1977

Regional Center	Agency Organization and Management	Percent of Courses with Content Related to					Public Information and Education
		Plan Development	Plan Review	Implementation Development	Data	Coordination	
I	40%	48%	20%	20%	36%	4%	32%
II	25%	46%	17%	17%	17%	--	17%
III	27%	58%	31%	--	15%	15%	2%
IV	38%	31%	28%	14%	3%	3%	17%
V	34%	45%	72%	21%	34%	34%	34%
VI	48%	55%	38%	17%	14%	7%	45%
VII	28%	56%	28%	6%	12%	--	4%
VIII	29%	76%	57%	19%	52%	33%	38%
IX	29%	48%	62%	10%	48%	24%	33%
X	38%	31%	13%	13%	6%	6%	44%
ALL CENTERS	34%	49%	37%	14%	23%	13%	28%

tional assistance and as a means of evaluating the effectiveness of each consultative intervention. Each Center views the consultative process as an educational process, in which the consultant provided by the Center works through problems with the agency rather than providing pat solutions.

The consultation activities of the ten Centers for Health Planning can be broadly categorized as major consultations, usually separately task ordered, and minor consultations, usually not task ordered and involving such things as telephone consultations, information searches, etc. During the period covered by this report, the ten Centers conducted a total of 930 task ordered consultations. Of these, 722 (77%) were consultations with HSAs and 208 (23%) were consultations with the state agencies or SHCCs. Consultant services were made available to 190 health systems agencies, 49 SHPDAs, and 32 SHCCs. In the category of non-task ordered consultations (e.g., telephone consultations, short-term in-office consultations, etc.) there were a total of 6,755 consultations conducted by the ten Centers for Health Planning of which 73% went to HSAs and 27% to state agencies and SHCCs.

Consultation services made available during the period covered by this report were also analyzed on the basis of the performance standards categories utilized by the Department. In the case of HSAs, the consultations were analyzed both by performance standard and client agency population-base. For SHPDAs/SHCCs, analysis was conducted on the basis of performance standards only.

Table III below summarizes the use of task ordered consultation services by client agency population category. Since the agencies are funded on a capitation plus basis, population size generally indicates agency budget. The results in Table III reveal that agencies with a population greater than one million, which make up 33% of all HSAs in the country, generated 45% of the task ordered consultation offered by the ten centers. The second category, with population of 500,000 to 999,999, constitutes 42% of the HSAs and generated 31% of the requests.

TABLE III

Distribution of Task-Ordered HSA Consultations  
by Client Agency Size, Ten Centers,  
January 1, 1976 - December 31, 1977

<u>Client Agency Population Category</u>	<u>Percent of All HSAs in this Category</u>	<u>Percent of Task-Ordered Consultations to this Category</u>
Greater than 1 million	33%	45%
500,000 - 999,999	42%	31%
250,000 - 499,999	19%	19%
Less than 250,000	6%	5%

The results of analyzing use of consultative services by HSAs according to the various performance standard categories are summarized in Table IV on page 12. In this case, as in training, the plan development and agency organization and management categories were the most frequent fields of consultation, followed by activities related to review programs of the HSAs.

The same relationships held for consultative services to SHPDAs and SHCCs. State agency consultative activities relating to plan development, however, constituted 39%, almost double the percentage of consultation activities in agency organization and management, and implementation/review.

#### GENERIC MATERIALS

The third major element of the centers technical assistance mission is the production of generic materials of various kinds. In this context, generic materials refers to any of a variety of training and technical assistance aids; orientation materials; informational materials; and audio-visual materials. Generic materials can be used independent of a specific training course or consultative activity, although they are often prepared to support such activities. Such materials are of particular importance in the initial phases of development of a new program. Among the desirable features of generic materials:

- (1) They provide a desirable degree of uniformity to developing program activities within dispersed agencies.
- (2) They can provide a rapid orientation to the field for participants in agency activities, and for those who deal with the agencies.
- (3) By their nature, they can reach a broader audience of participants than can formal training activities at a lesser cost.
- (4) Once prepared, they are available for continuous reference.
- (5) They have great potential for interchange among the centers for health planning and for inter-regional use.

Collectively, the ten centers have produced more than 80 documents, films, and video tapes since January 1, 1976. From the standpoint of topics covered, 45% of the generics produced dealt with issues relating to agency organization and management, 40% with issues related to plan development, 36% with issues related to project review and 28% with public information and education activities of the client agencies.

The centers have utilized a wide variety of media in producing their generic materials. Although the most common form is hard copy, such as pamphlets, study guides, syllabi, and reports, the Centers have also produced slide/tape presentations, motion pictures, and video tapes. Inter-regional use and sharing of generics has been high, with each center, on the average, utilizing generic materials from five other centers during the period covered by this Report. Wide dissemination among centers of information concerning generics produced by other centers is achieved through several

TABLE IV

HSA Consultation Services by Client Agency Size  
and Performance Standard Category, Ten Centers,  
January 1, 1976 - December 31, 1977

Client Agency Population Base	Agency Organization and Management	Percent of Consultations Offered by Performance Standard Category					Public Information and Education	Other
		Plan Development	Plan Implementation Review	Development	Data	Coordination		
Greater than 1 million	19%	36%	12%	2%	10%	1%	12%	8%
500,000 - 999,999	25%	34%	17%	4%	6%	2%	11%	1%
250,000 - 499,999	21%	31%	16%	1%	9%	2%	14%	6%
Less than 250,000	39%	18%	7%	--	7%	7%	18%	4%
All HSAs	24%	34%	14%	2%	8%	2%	12%	4%



means, including interchange of task orders for production of generics, distribution of copies of generic materials to all centers, and lists of generic materials available incorporated in newsletters and reports.

#### SUMMARY

This report has reviewed the activities of the ten regional Centers for Health Planning established as authorized by Section 1534 of the Public Health Service Act, as amended. The report summarizes a strong record of productivity in support of the overall goals of P.L. 93-641. The ten Centers for Health Planning have, in a relatively short time, established themselves as key resources for meeting the training and technical assistance needs of HSAs, SHPDAs, and SHCCs in their respective regions of the country. Materials produced by the various Centers have been widely distributed, course offerings have been heavily attended, and a large volume of direct consultative service has been offered.

A critical question, not answered by the statistical data included in this report, is--"Are the clients satisfied?" Appendix I to this report consists of unedited client responses to activities of the Centers conducted during the past two years. These responses speak eloquently to the issue of client satisfaction, and to the fact that the Centers are meeting a real need for specialized assistance on the part of the operating agencies.

## APPENDIX I

## Client Reactions\*

"As a result of [the center's] efforts and those of the committees, the applicant has withdrawn a \$5.5 million proposal with the intent of resubmitting a less ambitious proposal for \$2.5 to \$3.5 million."

--HSA Executive Director (Arizona)

"For the first time I think I really understand what the SHCC is suppose to do."

--SHCC Member (Tennessee)

"Without the technical resources provided by the [Health Planning Center], there would be a great void in the assistance available to the South Dakota HSA. It is definitely a valuable resource and a much needed aid to the agency."

--HSA Director (South Dakota)

"Your consultation was timely and extremely important, and candid comments hit upon many critical issues."

--HSA Associate Director (Oregon)

"The consulting aid was arranged on very little notice on our part...the request was made and response was immediate...[center staff and consultants] were well prepared when they came into the meeting...they did not provide a theoretical model. They worked through the process with us in application and practical examples based on our situation."

--HSA Director (Kansas)

"Marketing theory and applicability to social service agencies was helpful and insightful. Never made the connection before, and it is useful material."

--HSA Planner (Iowa)

"It [the Health Planning Center] also provided invaluable assistance to the agency at the agency's annual board retreat, at which time the working draft of the health systems plan was thoroughly reviewed by the Board of Trustees."

--HSA Chairperson (New Jersey)

"I wish to thank you for the assistance that your office has provided this agency during the past year especially with regard to the establishment of the statewide health coordinating council. I am certain that the council would not have been established by June of this year nor have progressed to the extent that it has without the commitment of time that [the center] gave to its establishment."

--SHPDA Director (New York)

NOTE: Comments and quotes from some centers were not received in time for inclusion in this report. They will be included in subsequent reports.

"The result of the workshop for me was very satisfactory...since our HSA was organized to use subarea councils, I feel this approach was well oriented...the workshop was good in helping establish relational aspects."

--Subarea Council Chairperson (Kentucky)

"Our corporation is very appreciative of the support and technical assistance available through [Health Planning Center] it is our opinion that your broad knowledge of the field and contacts with multi-disciplinary consultants is a real advantage to the southeastern region HSAs."

--HSA Director (Florida)

"Basic planning techniques will be useful in all planning, not just behavioral."

--HSA Planner (California)

"The review workshop surveyed the available information at just the right time..."

--HSA Plan Implementation Director  
(Oregon)

"Consultation document is a very good instrument to encourage a common planning approach throughout the state."

--HSA Director (Alaska)

"The long-range value of [the Center for Health Planning] is in their ability to assist agencies to develop greater planning capabilities, and to provide short- and long-range planning expertise to areawide and other state programs. I believe the concept of centers for health planning has a great deal of merit and should be continued for the purpose of successfully implementing P.L. 93-641."

--SHPDA Staff Member (Wyoming)

"You proved again what a valuable resource the [Center] and its staff can be to a health systems agency. We appreciate your presentations, and equally most helpful response to many questions."

--HSA Director (Illinois)

"We felt the entire session was received very well as evidenced in the stimulating question and answer period which continued well beyond the plan session end. Many comments have been received from board members indicating their satisfaction with the information discussed that evening, even as a review for those already familiar with the issues."

--HSA Chairperson (Minnesota)

"The Center is doing an excellent job. If our agency were to review your renewal contract, recommendation would be approval. The staff have attended seven meetings presented by the Center and all reports have been excellent."

--HSA Director (Ohio)

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

Dr. Kimmey, you are involved in health planning. Is that correct?

Dr. KIMMEY. That is correct.

Mr. CARTER. Do you believe in a regional concept of health delivery?

Dr. KIMMEY. I think that planning on a regional basis, as it has been embodied in this particular legislation, certainly has a number of advantages in terms of the very things the legislation set out to do, allocating resources on a regional basis, making sure services reach those who live in that region and that there are not excess services.

Mr. CARTER. Enough but not too much—so it is cost effective and yet does deliver health services as needed. Are you having many difficulties, now, with your health planning and your teaching? I notice you are teaching health planning, too.

Dr. KIMMEY. In our region, I work in the States of Minnesota, Wisconsin, Illinois, Ohio, and Kentucky, and we have 42 HSA clients. Of those, 11 are minimally funded HSA's. They have a minimum budget possible under the legislation.

We have offered, since we started in July of 1976, 32 courses for these folks, and in our particular case, over 1,400 people have attended these courses. Some of them have been directors and board members, some State staff members.

For the most part, we find that the people that come to the training courses are satisfied, that they get something that is useful to take back to their jobs.

When we have gone in 6 months later and asked again questions about the specific course content, again, they have indicated some of the things they have learned in these courses have been put into effect in their agencies. I would say we don't feel we are having a great deal of difficulty in this. Our greatest problem is reaching everybody that needs to be reached. There are 1,500 people on the boards of these agencies. We are only beginning to touch the need.

Mr. CARTER. Could you give a brief description of health services that could be offered in an ideal region?

Dr. KIMMEY. Well, if you are looking at direct services we would like to see offered, I think that first and foremost, there are two things that have to be there before you build the rest—adequate primary care services for all, and an adequate health care system.

Mr. CARTER. What do you include in primary care?

Dr. KIMMEY. I would include general practice, general medicine, long-term care within easy reach of the people that need it, including nursing home care.

I think that one of the problems in the whole regionalization issue is that we have not developed a good, useable, widely applied classification of services. You asked me my definition of primary care, and I would go on to define secondary and tertiary. I think we need to look at those fields together, so that a person that comes into contact with the system in a primary care setting gets access to all levels of service in an orderly fashion.

Mr. CARTER. Would you describe some of the secondary services?



Dr. KIMMEY. In secondary care types of services we would find more complicated types of specialty surgery, for example, the handling of complicated obstetrics.

Mr. CARTER. What do you mean by complicated obstetrics?

Dr. KIMMEY. Any woman who is identified as a high-risk mother, for example, or who may require a caesarean.

Mr. CARTER. What about a breech presentation?

Dr. KIMMEY. No. I think a breech presentation is a complicated obstetrical problem, but well within the reach of a primary obstetrician.

Mr. CARTER. You think that would come under primary care. What about a footling breech presentation?

Dr. KIMMEY. My experience is limited. We never know those were coming until they got here.

Mr. CARTER. Both of those are rather difficult, it seems to me they would come, certainly, under secondary care. The single footling breech mortality is quite high.

Dr. KIMMEY. I don't disagree. What I was trying to express is how you might classify the services rather than the cases in the system by complexity. I certainly agree that is a complicated obstetrical problem.

Mr. CARTER. You would still put it under the primary care. Caesarean sections—where do they come in?

Dr. KIMMEY. That can be done by a primary care obstetrician, as opposed to being referred to referral centers miles away.

Mr. CARTER. What about a ruptured uterus—what are you going to do with her?

Dr. KIMMEY. I would send for a mobile intensive care unit. I hope I am close enough to get one.

Mr. CARTER. I assure you we have got to take care of such things.

What do you consider tertiary care?

Dr. KIMMEY. Tertiary care are those things that are of a relatively low requirement within the population to be served by the tertiary facility, such as highly specialized things like open heart surgery, complicated diagnostic medical problems, the things that need the full scope of modern scientific medicine.

Mr. CARTER. Cardiac inferrings—would you include that?

Dr. KIMMEY. No; I think coronary intensive care units can be adequately operated at the secondary level.

Mr. CARTER. Well. Thank you very kindly.

Mr. ROGERS. Let me just say, if you would furnish for the record, any suggestions you would have regarding changes in the law required to improve the provisions which would be of technical assistance to HSA I think that would be helpful.

Dr. KIMMEY. We would be happy to do that.

Mr. ROGERS. There is a vote. The committee stands in recess for 10 minutes.

[Brief recess.]

Mr. WALGREN [presiding]. We will resume.

Dr. Carter will be with us shortly.

We welcome, now, a panel of health systems agency representatives and State agency representatives, Mrs. Dorothy Hoskin, presi-



dent of the board of Western Colorado Health Systems Agency, along with Mr. Dave Meyer, the executive director of Western Colorado HSA, and Col. Bertram Parr, vice president of the board, Health Planning Council of the Eastern Shore, of Maryland, accompanied by Mr. Fred Dierks, executive director of the Health Planning Council of the Eastern Shore, and Mr. Richard Neibaur, president of the National Association of Single State Agencies.

We are pleased you are here, and we would like to give you the opportunity to go forward with your statements in whatever way you like.

The written statements will be made part of the record. You may summarize them or read them as you see fit.

**STATEMENTS OF DOROTHY HOSKIN, PRESIDENT, WESTERN COLORADO HEALTH SYSTEMS AGENCY, INC., ACCOMPANIED BY DAVE MEYER, EXECUTIVE DIRECTOR; COL. BERTRAM PARR (USA RET.), VICE PRESIDENT, HEALTH PLANNING COUNCIL OF THE EASTERN SHORE, INC., ACCOMPANIED BY FRED DIERKS, EXECUTIVE DIRECTOR; AND RICHARD NEIBAUR, CHAIRMAN, NATIONAL ASSOCIATION OF SINGLE STATE AGENCIES**

Ms. Hoskins. Thank you.

I am Dorothy Hoskin, and we, today, represent 36 health systems agencies from across the country and these agencies have two things in common. First of all, they are minimally funded, which, under the law, means that they got the bottom line funding and they are mostly rural.

Unfortunately, the marriage of these two characteristics is often rather rocky. We have expended our meager funds to be here today to urge you, first of all, to please continue Public Law 93-641 basically intact. We feel it is a good law. It is doing exciting things in our areas. For example, we are finally planning for ourselves, which was not the case in the past.

Now, speaking directly to section 206 of your amendments, the topic of that section is funding, our primary problem is money, or shall I say, the lack of money. We urge you to increase the minimum funding level for HSA's to \$275,000, 70 cents per capita, with an inflation factor. We feel very strongly that we must get community participation in our planning process. When we are talking about a rural HSA, we are talking about communities that are 400 miles apart. Therefore, one of our primary costs is travel.

For example, one of our board meetings in one corner of our area cost \$1,200 just for the expenses. Most of these agencies are spending 10 to 15 percent of their budgets on travel. We also represent areas that historically have been medically unserved. They were not funded at the same level as CHP agencies, for example, therefore, the planning efforts are just now getting started. We do not have a historical record.

Now, the national push seems to be for costs containment. We hear that from many directions, but we have difficulty with it because our residents do not have primary care. In other words, it is not

available or accessible. What we need is creative resource development. We don't need to worry about cutting costs, because we are not spending because we don't have those particular things available in our areas. We figure that in order to do the job outlined, first of all in the law, and second of all as that law is interpreted by HEW, it would take at least seven professional staff people with support.

In our written testimony, we have included four pages that merely list the tasks that are required, in case you wondered what we have to do, you may refer to that. That will explain the enormous job that all of us have to do no matter whether we are big or little. We are complying but our five staff professionals are working 60 to 70 hours a week. This can't go on forever. Staff will burn out. Our salary levels are much lower than the larger agencies can offer. Therefore, we lose a staff person, we are really in trouble.

We would also like to point out that the legislation uses the word, minimum funding. I don't exactly know what the intent of Congress was, but I assume when they use minimum, that would mean that was the least amount we could get. You did not use the word maximum, however the HEW does use the word, maximum, on the same figure you call minimum.

Also, there was some supplemental funds given out in the last year, and they were appropriated on a per capita basis. Whenever you talk about per capita, we never see it. There is a certain problem in giving discretionary funds to HEW. I shudder when I think about what they might make us do to prove that we need those funds. Just to put together our grant application yearly costs 2 man months of work. In other words, we spend a lot of time on paper work and I fear that proving discretionary funds might also cost more staff time.

We urge you to give us enough to do the job properly and then let us do it.

Now, since we got together and did our analysis on what we honestly felt it would take to do the job, there has been a bill introduced in Congress, 10460. We studied these amendments. We have different feelings on the particulars, but if you go through and look at them and figure out what it would cost, because we are thinking about money, it would cost at least two additional professional staff because of the added responsibilities which would add about \$50,000 to what we would need to do the job. In other words, we got together and said, we can live with \$275,000, if they don't add anything, but if they add other things, we are still in trouble.

Now, I would like to speak specifically to one more section in the proposed amendments. That is section 223, which has to do with statewide health coordinating councils. While most of the proposals would strengthen Public Law 93-541, we violently oppose this particular one because we feel it does not strengthen the law at all. It speaks to HSA representation on the statewide health coordinating councils. It proposes that the representation be proportional to the population of the agency. This simply means that the large agencies in any State are going to control the ship. If we are going to have local planning, let's have local planning, let's let it work. Don't make the SHCC so overpoweringly urban that we are faced with urban

solutions to rural problems. That doesn't work. We feel the present law does give the Governor such opportunity to appoint urban people, if he wishes. He can choose 40 percent of the SHCC members, which is more than any HSA can choose. Whenever representation or funding is determined by population alone, the people who live in rural health service areas get less than their fair share.

### STATEMENT OF COL. BERTRAM PARR

Mr. PARR. Mr. Chairman, Congressman Carter.

I am Bertram Parr, a consumer of health care services, and I am the vice president of the Health Planning Council of the Eastern Shore of Maryland. I am a local farmer and businessman. Our agency consists of nine counties and some 260,000 people. You can see it is a rather small HSA area and very few people. I certainly support what my colleague has said here. I feel that many of the things, or most of the things she has mentioned also apply to my particular area on the Eastern Shore.

One thing I would like to emphasize, however, is although our agency is small, we still have the same responsibilities and functions that a larger agency does. We also have found that the minimum funding of \$175,000 a year is insufficient to do our job. We have been able to get by because we have raised local financial support of approximately \$50,000 each year, to supplement this \$175,000, so we really are operating on a budget, now, of \$225,000. We also feel that the \$275,000 would be what we need to do the job for the next year.

However, after reviewing your bill, which we saw yesterday, we find you have already recognized this problem and here in the House you have recognized a minimum funding of \$200,000. We would ask that you consider raising that to \$275,000.

Another problem we have which you may be interested in is the method used to qualify for Federal matching funds. As you know, your appropriation does set aside certain funds to the HSA to encourage local financial support. We have been very successful, as I have indicated, by raising \$50,000 for that, which represents approximately 20 percent of our budget. However, we feel that our agency is the only agency in the Nation which has contributed 25 cents per capita and hasn't received any Federal matching funds. Again, I see that you have anticipated this and it is in your bill, now, and hopefully, you can talk to your colleagues in the Senate and convince them it also should be there.

One last point I would like to make. I would like to put a plug in for the current organizational structure of the HSA, particularly provisions for the subarea council. We feel this is most important in a rural area to provide a basis for the HSA support, and also to provide for maximum input for planning decisions dealing with the local area, local counties.

That is all I have, sir.

[Testimony resumes on p. 1148.]

[Ms. Hoskin's, Dr. Brownrigg's, and Col. Parr's prepared statement follows:]



STATEMENT OF POSITION  
of the  
MINIMALLY FUNDED AND RURAL HEALTH SYSTEM AGENCIES

Submitted to  
THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
Committee on Interstate and Foreign Commerce  
House of Representatives

Presented by  
Dorothy Hoskin, President  
Western Colorado Health Systems Agency, Inc.

Richard L. Brownrigg, M.D., President  
Western Kansas Health Systems Agency, Inc.

Col. Bertram Parr, Vice President  
Eastern Maryland Health Systems Agency

For  
OVERSIGHT HEARING ON P.L. 93-641  
February 2, 1978

POSITION PAPER

ON

MINIMALLY FUNDED AND RURAL HEALTH SYSTEMS AGENCIES

## I. INTRODUCTION

A. Rural and minimally funded Health Systems Agencies support the concepts and Congressional intent behind Public Law 93-641, "The National Health Planning and Resources Development Act of 1974." P.L. 93-641 has consolidated efforts from competing Federal programs, improved and built upon the successes and failures of those programs, and extended the concept and functional viability of health planning to the entire country. Among the 200+ Health Systems Agencies across the nation are many small but tenacious organizations grappling with the problems of quality health services, adequate availability and accessibility, while attempting to meet necessary cost containment goals. The following Agencies comprise this dedicated group of consumers, providers, and professional staff actively implementing this Law:

Alabama Planning District IV Health Systems Agency, Gadsden, Alabama  
 Southeast Alaska Health Systems Agency, Ketchikan, Alaska  
 South Central Health Planning & Development, Anchorage, Alaska  
 Northern Alaska Health Resources Association, Fairbanks, Alaska  
 Central Arkansas Health Systems Agency, North Little Rock, Arkansas  
 South Arkansas Health Systems Agency, El Dorado, Arkansas  
 Western Colorado Health Systems Agency, Grand Junction, Colorado  
 Health Planning Association of Western Kansas, Hays, Kansas  
 Health Planning Council of Eastern Shore, Cambridge, Maryland  
 Merrimack Valley Health Planning Council, Lawrence, Massachusetts  
 Northern Michigan Health Systems Agency, Petoskey, Michigan  
 Upper Peninsula Health Systems Agency, Marquette, Michigan  
 H.S.A. of Western Lake Superior, Duluth, Minnesota  
 Central Minnesota Health Systems Agency, St. Cloud, Minnesota  
 Southeastern Minnesota Health Systems Agency, Rochester, Minnesota  
 Missouri Area V H.S.A. Council, Poplar Bluff, Missouri  
 Southeast Nebraska Health Systems Agency, Lincoln, Nebraska  
 Greater Nevada Health Systems Agency, Reno, Nevada  
 Health Systems Agency of Clark County, Las Vegas, Nevada  
 NY-Penn Health Systems Agency, Binghamton, New York  
 Western North Dakota Health Systems Agency, Bismarck, North Dakota  
 Agassiz Health Planning Council, East Grand Forks, Minnesota  
 Min-Dak Health Systems Agency, Moorhead, Minnesota  
 West Central Ohio Health Systems Agency, Lima, Ohio  
 Eastern Oregon Health Systems Agency, Redmond, Oregon  
 Keystone Health Systems Agency, Altoona, Pennsylvania  
 West Tennessee Health Association, Jackson, Tennessee  
 South Plains Health Systems Agency, Lubbock, Texas  
 West Texas Health Systems Agency, El Paso, Texas  
 Permian Basin Regional Planning Commission, Midland, Texas  
 Southwest Washington Health Systems Agency, Olympia, Washington  
 Central Washington Health Systems Agency, Moses Lake, Washington  
 Eastern Washington Health Systems Agency, Spokane, Washington  
 Lake Winnebago Area Health Systems Agency, Oshkosh, Wisconsin  
 North Central Area Health Planning Association of Wausau, Wisconsin  
 Wyoming Health Systems Agency, Cheyenne, Wyoming



B. In facing the serious challenges of P.L. 93-641, the foregoing group has had to struggle not only with problems indigenous to their areas, conflicting and confusing Department of Health, Education, and Welfare regulations, performance standards criteria and guidelines, but also a serious and crippling lack of adequate funding. Furthermore, many of these Agencies serve sparsely populated and immense geographic areas, often with rugged terrain, adverse weather and limited transportation networks.

Congress has mandated enormous responsibilities for all Health Systems Agencies throughout the country, regardless of their size. However, current funding, which is based primarily on a per capita dollar formula, often penalizes smaller Agencies in meeting the health needs of their residents. Notwithstanding the challenges faced, these Agencies have had notable successes, not only in meeting Federal Guidelines and expectations, but also community needs, in the short timeframe of less than two years.

## II. FUNDING PROBLEMS

A. A listing of activities mandated by Congress which each Health Systems Agency is required to perform is found in Attachment 1. This list also includes performance standards and expectation levels developed by the Department of Health, Education, and Welfare as a basis for measuring Agency compliance.

It is apparent from this list of activities that the responsibilities of all Health Systems Agencies are enormous. Where this affects the small, minimally funded, and rural Agencies to a greater extent is in the capacity to meet these standards with limited staff and resources.

Results of a survey recently taken with respect to the needs of these Agencies in meeting the above standards have clearly indicated that, under current funding levels, most of these Agencies do not have more than five professional and two clerical staff. The Bureau of Health Planning and Resources Development (BHPRD) currently requires Agencies to maintain records and activities in seven distinct functional areas:

- Agency Management
- Plan Development
- Plan Implementation/Project Review
- Plan Implementation/Resources Development

Data Management  
 Coordination  
 Public Involvement

Most Agencies surveyed estimate that, in order to adequately meet current expectations, a minimum or average of one staff member per function is an absolute prerequisite. Further, many feel that additional staff is necessary to comply with local needs and demands.

It should be noted that Congress has established a minimal funding level of \$175,000 in P.L. 93-641 to accomplish all of these tasks. Unfortunately, the Department of Health, Education, and Welfare interpretation has, for the most part, concluded that this is the maximum funding level for many of the Agencies previously listed.

The group asks that the Federal funding level be at least 70¢ per capita with a minimum of \$275,000, including a provision for inflation. Further, the group feels that the Secretary of the Department of Health, Education, and Welfare should be given 5% of the appropriation made under this Act for discretionary use. The Secretary would then have the ability to meet the needs of those Agencies which have extraordinary travel expenses caused by large geographic areas and/or sparse or widely distributed population; energy, or other growth impacts; multiple jurisdictions such as two state agencies or SHCCs; and other problems.

- B. The Agencies presenting this testimony extend across the Nation - North and South, East and West. Many face, as previously indicated, enormous distances, sparse population, difficult terrain, and significant adverse weather conditions. Public Law 93-641 demands public involvement of consumers and providers who are residents of the area in planning for their health. For issues to be discussed and resolved in a democratic manner, adequate provision must be made for insuring participation, involvement, and accountability by and with Health Service Area residents. From the survey, many of the small Agencies spend in excess of 10% of their total budgets on Board, Committee, and Staff travel.

Examples:

The Western Colorado Health Systems Agency spent \$21,150.00 for travel in FY 1976-77 and was only fully staffed and operational for approximately nine months. This amount represented 14.6% of its \$145,000 Budget. For FY 1977-78, its travel budget is projected at \$29,500 or 16.9% of \$175,000 allocated. Travel costs per meeting range from \$650.00 to \$1,200.00, depending on location and exclusive of overnight lodging.

The Health Planning Association of Western Kansas (HAWK) spends in excess of \$25,000 per year for the travel of its Board and six Subarea Councils to cover its 46,000 square mile area. Involvement includes 57 Board Members meeting monthly and 210 Subarea Council members meeting bi-monthly.

Involving the public in crucial health planning decisions is, perhaps, one of the few rational approaches to overall cost containment for health services. Comparing Agencies covering 40,000 square miles and spending fifteen percent of their budget on travel with those of 400 square miles and spending less than five percent, is a major point that Congress should review and consider as part of these Oversight Hearings.

### III. RURAL PROBLEMS

- A. Previous Congressional Reports such as The Economic and Social Condition of Rural America in the 1970's (prepared by the U. S. Department of Agriculture, December 1971) have found that rural Americans do not share proportionately in programs funded by the Federal Government. Federal spending on Human Resource Development (Health, Education, Welfare, Vocational Rehabilitation, Manpower Training and Development) favors metropolitan counties over rural areas.

#### Examples:

- per capita outlays under conditions of pronounced population decline for health services are 4 times greater - welfare payments 4 times greater - manpower training and development 3 times greater - in metropolitan counties than in rural ones;
- rural counties account for 66% of all substandard housing units but receive only 16% of all Federal housing assistance;
- rural counties account for 50% of all children between the ages of 6 and 17 in poverty level families, but receive only 20% of all Federal child welfare service funds - 24% of Federal aid to families with dependent children - 26% of Federal headstart and followthrough assistance; and 41% of Federal outlays for elementary and secondary educational programs aimed at meeting the specific needs of disadvantaged children in low income areas.

The entire history of Federal support for local regional health planning has been one of underfunding for rural areas. While 27% of all Americans live in rural areas, only 15 to 20% of health planning monies go into rural areas. Comprehensive health planning for rural areas, if accomplished previously, tended to be done by state departments rather than by areawide rural health planning agencies.

Although the present health planning legislation provides for total geographical coverage by Health Systems Agencies with a minimum funding level of \$175,000 for less populous Agencies, we suggest that health

planning in rural areas remains underfunded. A large part of the work of the rural Health Systems Agency is in the Plan Implementation/Resources Development function, in addition to being concerned with cost containment issues relating to inappropriate service development.

This commitment to resource development should be evident from the correlation between "Critical Health Manpower Shortage Areas" (CHMSA) and "Medical Underserved Areas" (MUA) and the areas covered by rural Health Systems Agencies. Furthermore, the need for making health services more available and accessible in rural areas has been recognized by Congress, as evidenced by item (1) of the National Health Priorities of P.L. 93-641"

Sec. 1502. The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

- (1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

Increasing the minimum funding base for rural Health Systems Agencies will not only strengthen the implementation of P.L. 93-641 in approximately 40% of the Nation, but will help ensure the most effective and efficient utilization of health resources. Adequate financial support is essential for effective rural health planning, and effective rural health planning is a requisite for assuring that health care services are available, accessible, and acceptable for all residents of rural areas.

- B. Historically, Federal approaches to health problems have been categorical; most programs have focused on individual groups or populations with specific problems or diseases. While we understand there are complex pros and cons concerning categorical programs versus block formula grants or the revenue sharing approach, the dominance of categorical programs places a great burden on Health Systems Agencies, especially minimally funded Agencies with few staff resources.

Although P.L. 93-641 was very successful in consolidating the Regional Medical Programs, Comprehensive Health Planning and Experimental Health Service Delivery Systems, there still remains fragmentation of health planning efforts in most Health Service Areas. Planning for implementation of Emergency Medical Service is an example. The insulation of the

Veterans Administration and their own internal planning is another. Furthermore, there are many state efforts (often with Federal support) that also fragment health planning in rural areas.

More recognition and support on the part of all Departments and Programs of the Federal and State governments could go a long way to assist rural health planning agencies in acquiring the critical mass necessary to accomplish their planning and development responsibilities.

- C. There are great difficulties for rural Health Systems Agencies in developing an adequate data base. There are a number of factors contributing to this problem such as the present legal restrictions on the collecting of primary data in the absence of assistance from other sources. Rural Health Systems Agencies generally are dependent upon data supplied by health care providers, such as small rural hospitals who may not keep records on such items as discharge diagnosis. However, in cases where they do, such data are often not uniform with other facilities in the area. In addition, Health Systems Agencies are held accountable for cost containment but Federal and State governments are often restricted in disclosing financial information that is routinely provided by health care provider groups.
- D. Another concern of the rural Health Systems Agencies are the recently proposed and revised Department of Health, Education, and Welfare Guidelines for Health Planning. This group maintains that the need exists for a balanced approach which includes strong health planning, appropriate health service development, and regulation.

The group supports active participation in the development of cost containment strategies that accurately reflect the unique needs of their Health Service Area residents. It should be recognized that the Guidelines are useful in establishing debate and focusing concern on necessary cost containment initiatives. It should be remembered that the Guidelines are, in fact, only experimental estimates which serve as guidance not law.

#### IV. RURAL HEALTH PLANNING SUCCESSES

- A. Despite the problems, limitations, and constraints under which rural Health Systems Agencies must operate, they have experienced some rather significant successes. Below are examples of the positive experiences of



several rural Health Systems Agencies.

Examples:

-The Southeast Nebraska Health Systems Agency has been instrumental in assisting its Health Service Area residents by the designation of three Critical Health Manpower Shortage Areas (CHMSA). These designations establish the basis for acquiring National Health Service Corps personnel and improving the Availability and Accessibility of health services for area residents.

-The Western North Dakota Health Systems Agency has not only been active in establishing CHMSA sites but has coordinated the development of a Poison Information & Treatment network for its area. Further significant impact and cost containment efforts in the amount of two million dollars have resulted because of agency discouragement, denial or alteration of projects submitted for review.

#### V. AGENCY SUPPORT, SPECIFIC PROBLEMS AND SUCCESSES

In consolidating this Position Paper, effort has been made to recognize and include the unique and varied needs of many Health Systems Agencies; those who are minimally funded; those which are predominantly rural; and those which are both.

Many other agencies contacted share the above constraints and it is evident that they also are seeking an opportunity to voice their individual and collective concerns. The Minimally Funded and Rural Health Systems Agency spokesmen have endeavored to bring to these Hearings basic issues which are faced daily by these Agencies. Appended to this Position Paper are specific indications of support, localized agency problems, and other agency successes (see Attachment 2). Should this Committee desire to discuss these matters further, it is urged to directly contact any agency listed.

ADDITION TO POSITION PAPER

This Addition was made after the Position Paper was prepared. The Senate and House Bills had not been received in time to incorporate the following statements in such Position Paper.

Reference is made to House of Representatives Health Bill No. 10460, Section 223, Statewide Health Coordinating Council composition.

1. While most of the proposals in H.R. 10460 would strengthen P.L. 93-641, the minimally funded and rural Health Systems Agencies are strongly opposed to Section 223 (a) and (b).

2. This Section speaks to HSA representation on the Statewide Health Coordinating Council, proposing that it be proportional to the population of the Agency.

3. We feel that the present Law gives the Governor sufficient opportunity to increase metropolitan representation if he wishes which was done in Colorado. Please note that the Governor chooses 40% of the SHCC members, more than any HSA.

4. Whenever representation or funding is determined by population alone, the people who live in rural Health Service Areas get less than their fair share.

LEGISLATIVE REVIEW OF TITLES XV AND XVI OF THE PUBLIC HEALTH SERVICE ACT  
(P.L. 93-641)

Testimony of Col. Bertram Parr, Vice President, Health Planning Council of the Eastern Shore, Inc., Maryland HSA5

Mr. Chairman, Committee Members, Ladies and Gentlemen:

Thank you for allowing me the opportunity to share some thoughts with you concerning health planning. My name is Bertram Parr, I am a consumer of health care services, and I am the Vice President of the Health Planning Council of the Eastern Shore, Inc., a conditionally designated HSA in the State of Maryland.

First, I support the statements of our colleagues in small population rural HSA's regarding the need for increasing the minimum level of funding. Since our agency and others like it are responsible for the same number of activities under the law as large, well financed agencies, we feel at a definite disadvantage. I believe that the problems are clear, and that the minimum funding level should be raised.

Another area of concern to us is the method used for determining federal matching of local dollars supporting the health planning program. As you are probably aware, a portion of your appropriation is set aside each year to financially encourage HSA's to develop local financial support. Because of the formula utilized in the current law it is virtually impossible for small rural HSA's to capture additional federal resources by raising money locally.

Our corporation was established in 1970 for the purposes of health planning under previous legislation, and since that time we have attracted \$346,000 in state and county appropriations. Even at this level of local participation no additional federal resources have been made available to our agency.

As a further example, let's look to the FY 1976 allocation. That year the Health Planning Council of the Eastern Shore was the only agency in the nation to locally raise more than 25 cents per capita and not receive any federal matching funds. It is for these reasons that we are very pleased to find that HR10460 as drafted alters Section 1516 of the current law. It is my understanding that the proposed amendment will allow HEW to match local funds for agencies receiving the minimum grant. We urge that this proposed amendment remain in the House legislation, and also urge that the same language be incorporated into the Senate legislation.

Thank you for your time and attention.

## ATTACHMENT 1

AGENCY ORGANIZATION AND MANAGEMENT

Establish policies for organization structure, governance, and operation of Agency.

Ensure public notice of all HSA activities and meetings.

Develop and monitor work program and budget.

Establish and maintain internal management reporting system.

Establish and maintain financial administration system.

Develop personnel policies and procedures.

Develop and maintain on an ongoing basis training programs for the Governing Body, staff, committees, Subarea Advisory Councils, etc.

Maintain staff which meets the requirements of the Law.

Main Governing Board which meets the requirements of the Law.

PLAN DEVELOPMENT

Coordinate planning with Federal, state, and local agencies and organizations.

Conduct public hearings on the H.S.P.

Publish and disseminate HSP to area libraries, the SHPDA, SHCC, and other state and local agencies.

Conduct Annual Review of HSP.

Establish procedures and process for Annual Review.

Involve the community in the development of the HSP.

Develop Annual Implementation Plan to describe objectives and priorities to achieve the goals of the HSP.

Ensure notice of AIP availability.

Publish and disseminate AIP to area libraries, SHCC, SHPDA, and other state and local agencies.

Review AIP annually and amend, as necessary.

Identify, collect, and analyze pertinent data  
- health status  
- health system

Establish goals and priorities in the HSP.

PLAN DEVELOPMENT CONTINUED

Identify and analyze the unique needs of the areas population

- manpower
- facilities
- financing

Quantify goals for:

- community health promotion and protection
- prevention and detection
- diagnosis and treatment
- habilitation and rehabilitation
- maintenance
- support services
- enabling services

Address these service categories by settings.

Describe a healthful environment and health system. Address:

- availability
- accessibility
- cost
- acceptability
- continuity
- quality

Considers national and state guidelines and priorities in developing HSP.

Coordinate HSP development with SHPDA, SHCC.

Revise HSP to meet coordination of statewide needs as required by SHCC.

Explain relationship between HSP and AIP and ensure consistency between these two documents.

Prioritize AIP objectives that maximally improve health at least cost.

Seek to implement HSP and AUP.

Publish specific plans and projects for achieving the objectives established in the AIP.

PLAN IMPLEMENTATION/REVIEW ACTIVITIES AND HEALTH SYSTEM DEVELOPMENT

Develop criteria and procedures regarding evaluation of need for:

- modernization, construction, and conversion of medical facilities
- other plan facilitation activities
- new institutional health services
- appropriateness review
- certificate of need review
- Section 1122 review
- other plan implementation activities
- PUFF



- Area Health Service Development Funds

Review the need for new institutional health services and make recommendations to the State Agency.

Review on a periodic basis (at least every five years) all institutional health services and make recommendations to the State Agency regarding the appropriateness of such services.

Annually recommend to the Secretary of DHEW and State Agency:

- A. Projects for modernization, construction, and conversion of medical facilities.
- B. Priorities among such projects.

Review and approve or disapprove or review and comment upon as appropriate . . . each specified Proposed Use of Federal Funds within the Health Service Area.

Identify relationship between health status and health system goals.

Spell out long range recommended actions and resource requirements or implications in terms of manpower, facilities, equipment, and financial impact.

Develop procedures and policies for conflict of interest in Project Review.

Establish coordination between HSA and other agencies engaged in concurrent review of projects.

Establish policies, procedures, activities to ensure public involvement.

Provide consultation and technical assistance to prospective applicants in the preparation of proposals for review and other projects and programs which meet the objectives and priorities of the HSP and AIP.

Develop a monitoring and tracking system to assure that timely information is available on reviews.

Establish a post-review system to insure execution of projects as approved.

Maintain data on applications and/or consultations.

Develop Memoranda of Understanding with SHPDA, A-95 Clearinghouses.

HSA involvement in local, state, and national issues concerning health status of area residents and health system in area.

Make grants and enter into contracts with public and non-profit entities to assist them in planning and developing projects and programs which will achieve the objectives of the HSP.

DATA MANAGEMENT AND ANALYSIS

Identify, collect, and analyze data concerning:

- health status of area residents
- status of health care delivery system and use by residents
- effect of system on residents
- number, type, and location of area resources
- patterns of utilization of the area's health resources
- environmental and occupational exposure factors affecting immediate and long term health conditions

Develop policies, procedures, and systems for organizing, storing and retrieving information of the above types.

Coordinate data acquisition and analysis with the Cooperative Health Statistics System (CHSS), through an agreement with the CHSS, SHPDA, PSROs, other HSAs, A-95 Agencies, and other appropriate Federal, state and local agencies.

COORDINATION

Develop, adopt, and implement written agreements for the coordination of HSA activities with PSROs and A-95 Agencies in the area.

Coordinate in the areas of data, review, and input of documents, technical assistance, and implementation.

Coordinate activities with other Federal, state, and local entities.

PUBLIC INVOLVEMENT & EDUCATION

Develop and adopt procedures for public information and education regarding HSA functions and responsibilities.

Establish policies and procedures regarding public review and inspection of Agency documents, records, and data.

Ensure adequate notice of all meetings and hearings.

Develop an annual report concerning the activities of the Agency.

Develop and adopt policies and procedures for receiving public input on Agency functions and activities.

Develop, maintain, and make available for public inspection and copying, an index of the records and data of the Agency.

Develop strategies and programs for educating area residents about personal health care and services.

Provide each Indian Tribe which is located within its Health Service Area information respecting the availability of Federal Funds.

## ATTACHMENT 2

Individual Agency documentation for "Supporting Information for Minimally Funded and Rural Health Systems Agencies."

Additional documentation is still being submitted and will be forwarded to Committee Staff as obtained.

## WESTERN COLORADO HEALTH SYSTEMS AGENCY

2525 North Seventh Street

Grand Junction, Colorado 81501  
(303) 245-3590

January 31, 1978

### SUPPORTING INFORMATION FOR MINIMALLY FUNDED AND RURAL HEALTH SYSTEMS AGENCIES

#### A. General Support of Position Paper by Western Colorado Health Systems Agency

The Western Colorado Health Systems Agency supports the Minimally Funded and Rural Health Systems Agencies' concepts presented in the Position Paper. Our Agency has actively supported the efforts of this group to present to Congress the special problems faced by small Agencies.

Our Health Service Area covers 40,000 square miles and includes extremely rugged terrain that is often impassable in winter. The 215,000 people of Western Colorado represent approximately 1% of the total United States population. This population, however, is augmented by significant year around tourism. Further, Western Colorado contains some of the major energy resource reserves of the United States, including oil shale, low sulphur coal, uranium, oil, and gas. The development of these resources is just beginning to occur and impact the overall health, lifestyles, and services available to permanent and new residents.

#### B. Specific Problems Pertaining to Western Colorado

As previously noted, the enormous area, rugged terrain and severe climate provide many challenges to the Health Systems Agency in accomplishing the myriad of tasks required. Specifically, the involvement of area consumers, providers, local elected officials and limited professional staff is curtailed by insufficient travel monies. Board and Committee involvement, a commitment to "bottoms-up" planning, and adequate opportunity for review and comment by interested parties demand sufficient funding and extensive meeting and hearing schedules. This cannot be accomplished when travel funds must be secondary to maintaining Agency operations.

Concern has also been expressed on the recent Federal Guidelines which make no provision for the consideration of impact areas. The Guidelines, as revised and reissued, would still require crisis solutions to problems brought on by such population shifts.

#### C. Agency Successes and Activities During Initial Operation

In the face of adversity, the Western Colorado Health Systems Agency has obtained notable success in several important areas.

1. The thrust of the Agency is to help solve health problems faced by the rural inhabitants within its area. Our Agency has been intimately involved in assisting the communities of Hayden, Collbran, Telluride, and Silverton to acquire National Health Service Corps personnel. These communities have been designated as Critical Health Manpower Shortage Areas and Medically Underserved Areas, qualifying them for assistance by the Corps and under the Rural Health Initiative Program.

In one instance, this Agency was directly involved in assisting with the preparation of the application of the Plateau Valley Hospital District for Section 1625 monies under P.L. 93-641 for the completion of their facility.

2. The Agency has adopted policies and positions in support of Health Promotion/Protection, Prevention, and Alternatives to the Institutionalization of the Elderly. Related to this area are several Health Systems Plan components on Public Health Services, Personal Responsibility for Health, School Health Education, and others.

The Agency, in cooperation with the Colorado State University Cooperative Extension Service, shares a full-time Health Educator, and is providing health education through the "Healthwise" series to local communities with the assistance of local School Districts, Colleges, and community groups.

The Agency, in conjunction with the Rocky Mountain Area Agency on Aging, and Mesa College sponsored an all-day workshop on the Alternatives to the Institutionalization of the Elderly for area residents. This workshop featured a speaker from the Institute of Medicine, nationally known specialists and state officials. The meeting drew over two hundred participants and attendees.

3. The Agency is undertaking its responsibilities of Project Review, has had success in reducing the overall cost of health services. One notable instance was in the revision downward of one million dollars from the applicant's original request. Further, the Agency has served notice and acquired through negotiations cooperation between facilities in an effort to share services and resources.
4. We are fortunate to have a hard-working corps of volunteers, both providers and consumers, serving on our Subarea Advisory Councils and many Task Forces, led by a dedicated Board of Directors and Staff.

Respectfully submitted,

*Dorothy D. Hoskin*

Dorothy D. Hoskin, President  
Board of Directors  
Western Colorado Health Systems Agency



## southeast nebraska health systems agency

Jane Ford  
Executive Director

ROOM 417 • 215 CENTENNIAL MALL — SOUTH  
LINCOLN, NEBRASKA 68508

January 28, 1978

✓ Dorothy D. Hoskins, President  
Western Colorado Health Systems Agency  
2525 North Seventh Street  
Grand Junction, Colorado 81501

Richard L. Brownrigg, M.D., President  
Health Planning Association of Western Kansas  
1010 East Seventeenth  
Hays, Kansas 67601

Dear Ms. Hoskins and Dr. Brownrigg:

This is in response to your letter of January 23, 1978, regarding the position of the "minimally funded and rural" HSAs.

I have attached a letter from our Board President as you requested. You will note that our Board did unanimously support the minimum funding level we discussed.

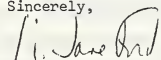
Also, the Board did authorize a Board representative to testify if needed regarding the renewal of P.L. 93-641. However, considering our serious financial situation this would be done at my discretion. Several individuals have expressed interest. These include: Bill Boyce, President; Margrethe Ahlschwede, Vice-President; and Floyd Vrtiska, Treasurer.

I assume I will be contacted regarding the necessity of additional individuals to provide testimony.

With respect to your last request for financial assistance, I will contact Dave Meyer directly to determine how we might be of assistance.

I appreciate the opportunity of meeting and talking with you both last week. On behalf of the Southeast Nebraska Health Systems Agency, I want to thank you for your willingness to represent our interest in testimony.

Sincerely,



M. Jane Ford  
Executive Director

MJF:crf

Attachment

its purpose is to improve the health of the area's citizens and provide guidance to the health care system. Consumers, providers, and government are involved in the organization and operation of the Agency.

## SOUTHEAST NEBRASKA HEALTH SYSTEMS AGENCY

Supporting Information For Position Of  
Minimally Funded And Rural Health Systems Agencies

## A. General Support of Position Paper by Southeast Nebraska Health Systems Agency

On January 25, 1978, the Southeast Nebraska Health Systems Agency Board of Directors unanimously voted to support the position of the Minimally Funded and Rural Health Systems Agencies as expressed in the Position Paper. In doing so, the Board specifically endorsed a minimum funding level of \$275,000; however, expressed concern that this be achieved by the reallocation of funding to Health Systems Agencies across the country rather than by increasing the total Federal allocation for implementation of the Act. The SeNHSA continues to support the efforts of the Minimally Funded and Rural Health Systems Agencies to advise Congress and the Administration of the unique problems faced by small agencies such as ours.

## B. Special Problems Pertaining to Southeast Nebraska Health Systems Agency

The Southeast Nebraska Health Systems Agency is a private non-profit corporation formed under P.L. 93-641 to serve 17 counties in Southeast Nebraska. These 17 counties in southeast Nebraska cover nearly 10,000 square miles and include 372,000 people. Approximately  $\frac{1}{2}$  of the population of the area is concentrated in Lincoln, the area's lone SMSA. The balance of the population places additional demands on an agency with limited staff and financial resources. The nature of urban and rural health care problems are quite different.

The problems of the rural areas involve the development of primary health care and preventive services. The problems of the urban areas relate to the containment of the possible proliferation of existing services. These problem areas are equally pressing and require our health systems agency to maintain a high level staff capability to respond to these divergent problems. In the

face of this, the limited funds available to the agency make it difficult if not impossible for us to compete with the other health systems agencies in recruiting experienced staff. Further, our location in the midwest seems to present another handicap to our recruitment efforts. This is exemplified by the fact that we have had a position vacant for as long as three months in an effort to attract planners with experience in coping with the health care problems of our area. This is not to say that the staff of our agency is of poor quality. What it does mean is that considerable resources of the agency must be spent in training less experienced staff to do the job and then often to see those same staff members leave for higher paying positions in larger health systems agencies and other organizations. Finally, the size of our area necessitates more staff time spent in travel and more money spent in reimbursing volunteers who travel as much as 5 hours round trip to attend meetings. This puts an additional strain on our limited budget.

#### C. Agency Successes and Activities During Initial Operation

Despite the obstacles which were described previously, the Southeast Nebraska Health Systems Agency has made notable progress since it was conditionally designated on May 10, 1976. The following represents the highlights of this progress:

1. The agency has developed a Health Systems Plan which is analytically derived, quantitative, and represents the direct involvement of over 180 individuals and groups. The Annual Implementation Plan and the Project Review Procedures and Criteria will receive final Board action in February with full designation anticipated in May, 1978. The overall emphasis of the agency plan is on the development of prevention and detection services, the development of primary care services in the rural areas, the development of home health services, and the containment of the existing system of facilities and equipment
2. The agency caused an increase in the availability of funds for home health services in the counties with defined need and prevented the funding of expansion of these services in areas where there was not demonstrated need.

3. The agency has discouraged the acquisition of equipment and/or the construction of facilities in at least seven instances in which the need for acquisition or construction was questionable.
4. The agency has identified areas of need and encouraged the development of services in those areas by providing information about the availability of usable funds and by providing technical assistance. Specifically, the agency has assisted in the designation of three Critical Health Manpower Shortage Areas.
5. The agency has generated the support and respect of a broad range of individuals and organizations not enjoyed by the agency's CHP-B agency predecessor. This is exemplified not only by the direct involvement of county officials in the membership and operation of the agency but by the level of financial support they provide. The agency is seen as representative of the diverse interests of the area as well as accountable to the people it serves.

In summary, the Southeast Nebraska Health Systems Agency Board of Directors is proud of its accomplishments yet cognizant of the additional press of responsibilities full designation will place on the agency. While the agency has made the best of its limited funds up to the present, we are concerned that the funds available to the agency are not adequate for continuing effectiveness in fulfilling its mandate. Consideration of our concerns will be greatly appreciated.

Respectfully submitted,



William R. Boyce, President  
Board of Directors  
Southeast Nebraska Health Systems Agency

January 28, 1978



## *Agassiz Health Systems Agency*

123 DE MERS AVENUE  
EAST GRAND FORKS, MN 56721

DONALD E. DE MERS  
Executive Director

### OFFICERS:

Paul Moutat, Chairman  
Emil Bagley, Vice-Chairman  
Clarence Lee, Secretary  
Jacob Burke, Treasurer

January 26, 1978

### BOARD:

Margaret Allmaras  
Rev. Carroll Anderson  
Arthur Blden, Jr.  
Jerry Blanchard, D.C.  
James Brown, M.D.  
Eileen Claxman  
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William Decoteau  
Jeanne Dempsey  
Allan Dragseth  
Paul Ericson  
Robert Ekeren  
Walter Fenske  
Carl Gorenson  
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Jean Hanson  
Rosemary Henderson  
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Stanley Holstad  
Howard Hove  
Jann Hurley  
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Marlys Jackson  
Richard Jackson  
John Jensen, M.D.  
W.D. Johnson  
Kenneth Koch  
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Garth Lords  
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R. D. McBane, M.D.  
LaVone Mogen  
F. W. Paulsberg  
Bonnie Reilly  
Patricia Reiten  
Juan Rodriguez  
Erma St. George  
David Sande, D.M.D.  
John Sipe  
Karen Sollom  
Gordon Sommers  
Lola Stankiewicz  
Lee Swanson  
Karen Sweeney  
Mark Turk  
John Vennes, Ph.D.  
Mary Wied

Dorothy D. Hoskin, President  
Western Colorado Health Systems  
Agency Board of Directors  
2525 North 7th Street  
Grand Junction, CO 81501

Dear Ms. Hoskin:

This letter is to again reiterate our firm support for increased funding requests and rationale presented in the January 23, 1978 Position Paper of Minimally Funded and Rural Health Systems Agencies.

The rationale presented clearly in the position paper definitely supports the need for an increased funding level for our HSAs.

I attach a letter of specifics of our agency which we sent to Bernardo Benes, President of American Health Planning Association and others in strong support of increased funding request.

We will send the position paper to all our Congressmen in hopes they will give due attention to the needs of our rural HSAs.

Sincerely,

A handwritten signature in cursive script that reads "Emil Bagley".

Emil Bagley, Chairman  
Board of Directors

rm1

Enclosure

cc: Richard L. Brownrigg, M.D., President  
Health Planning Association of Western  
Kansas Board of Directors





## Agassiz Health Systems Agency

123 LEAHYS AVENUE  
EAST GRANGE, FORKS, WA 98721

DONALD E. DE MERS  
Executive Director

UP: CURS:

December 12, 1977

Paul Wustat, Chairman  
Earl Bagley, Vice-Chairman  
Clarence Lee, Secretary  
Janice Burke, Treasurer

WAME:

Marjaret Allmaras  
Rev. Carroll Anderson  
Arthur Bilden, Jr.  
Jimmy Blanchard, D.C.  
James Brown, M.D.  
Elmer Clasen  
J.C. Connor  
William Gerotau  
Joanna Demsey  
Allen Dragseth  
Paul Eischen  
Robert Eichen  
Killer Fenske  
Carl Geranton  
Wilfred Hallstrom  
Lee Hamilton  
John Jensen  
Katherine Henderson  
John Hillis  
Stanley Holstad  
Howard Howe  
Joann Hurley  
Robert Jacobson  
Mervyn Jackson  
Richard Jackson  
John Jensen, M.D.  
W.D. Johnson  
Kenneth Koch  
Albert Koop  
Robert Koser  
Sandra Kuznia  
John Landon, M.D.  
David Lamm  
David Lamm  
David Lamm  
Rev. John Lee  
David Leonard  
George Lindenberg  
Garry Lord  
Jean Miller  
K.D. McBane, M.D.  
Lynne Mogen  
F.W. Paulsberg  
Bessie Reilly  
Patricia Reiten  
Juan Rodriguez  
John St. George  
David Tande, D.M.D.  
John Sipe  
Karin Solim  
William Somers  
Lori Stanislawski  
Lee Swenson  
Karen Sweeney  
Paul Turk  
John Thomas, Ph.D.  
Mary Wied

Mr. Bernardo Benes, President  
American Health Planning Association  
2560 Huntington Avenue, Suite 305  
Alexandria, VA 22303

Dear President Benes:

I am writing this letter to share with you the deep concern our agency has for its very survival. Our bi-state health systems agency of 27,000 square miles and 314,000 citizens under present funding levels will soon not be able to function.

If I may note some of our budgeting concerns:

1. Last year our agency received only \$145,000 and we had to spend \$10,000 hard earned local monies.
2. This year our agency will have to spend \$15-20,000 over the minimum funding of \$175,000.
3. Next year will reduce any local monies we have to about zero; and if there is no increase in the minimum grant I will be forced to let go staff (a catch 22 since I'm supposed to have five professional staff).
4. To compound matters - because of our population base we have not been allowed to match for monies over the \$175,000 --- a process I believe was intended.

Rural Health Systems Agencies must perform the same major 18 regulated functions as any metropolitan HSA. They usually can only afford five professionals (and they must compete with adequate salaries). Rural HSA's also attempt to retain their staff longer (we can't afford a 20% turnover regularly) and this contributes to salary increases etc.

For the above noted reasons, I implore you to have your legislative committee recommend minimum funding levels of \$225,000 to \$250,000 to Congress.

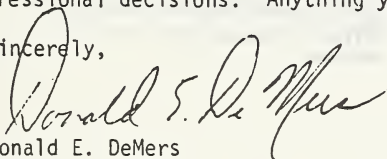
Our agency has been a dues paying member of AACHP now AHPA since its inception. I hope to be able to continue to support AHPA - but we need your help.

I additionally request that AHPA consider supplemental funding for bi-state agencies. We do incur additional costs as the following summary notes:

1. We have had to have extra meetings in Minnesota and North Dakota with SHPDA's to arrive at a common plan development process.
2. Our rural area covers over 27,000 square miles -- we have to get out in the field.
3. Time/distance costs for my Board are obviously compounded.
4. Review activities have necessitated extra meetings on 1122 and Certificate of Need (especially in developing new legislation).
5. There is a time loss factor of my minimum staff of five having to be gone so often.
6. Because of the newness and confusion of the legislation we've had significant pressure to attend technical assistance meetings.
7. It is imperative to note, that every agency (regardless of staff size) must meet all of the major items noted in the law and regulations -- not including all the other activities attendant on an HSA.

I appreciate AHPA, and I appreciated your comments at last June's annual meeting. I believe AHPA has the credibility to affect congressional decisions. Anything you can do will be appreciated.

Sincerely,

  
Donald E. DeMers  
Executive Director

1b

cc: Frank Armstrong  
S.E. Colorado HSA  
Member AHPA Legislative Committee

## HEALTH SYSTEMS AGENCY

ALABAMA PLANNING DISTRICT IV

JOHN A. BROWN  
EXECUTIVE DIRECTORANDREW A. CHAFFIN  
ASSOC. EXECUTIVE DIRECTOR

Ms. Dorothy D. Hoskin, President  
Western Colorado Health Systems Agency  
Board of Directors  
2525 North 7 Street  
Grand Junction, CO 81501

Dear Ms. Hoskin:

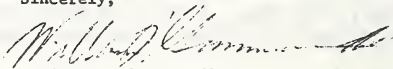
Your position concerning the need for additional funding for rural HSA's is supported completely by the Governing Body of our HSA. As you well know, small HSA's in rural areas spend a disproportionately amount of their time and resources to do the job as opposed to an urban or larger HSA.

Our HSA is not as sparsely populated nor covers the geographical area as some HSA's and I frankly don't see how they can even get by. In our case, we are able to get by only with some outside assistance which is minimal, uncertain and temporary at best. We have two professional staff people and three support staff funded by Comprehensive Employment Training Act (CETA). Additionally, we have one staff professional funded by Appalachian Regional Commission. All of these staff persons may become non-existent at any time. Further, without these people we really would be taxed to do any kind of an adequate job.

I would encourage the members of Congress to consider the points made in your position paper. If I could operate from a HSA office in a central city situation, we could double the effective man hours of our present staff. This is a pretty high price to pay for being rural.

I assure you that we support the representation to the Congress. Further, if our agency can be of assistance, please feel free to call on us.

Sincerely,



William R. Gammon, M.D.  
Chairman

RECEIVED JAN 29 1978

# WESTERN NORTH DAKOTA HEALTH SYSTEMS AGENCY

209 NORTH SEVENTH STREET BISMARCK, NORTH DAKOTA 58501 AC 701-223-8085

Friday, January 27, 1978

Dorothy D. Hoskin, President  
Western Colorado Health Systems Agency  
2525 North Seventh Street  
Grand Junction, CO 81501

Dear Mrs. Hoskin:

The Western North Dakota Health Systems Agency hereby offers its support and endorsement to the concepts and statements included in the position paper which is scheduled to be presented into testimony in Congressional Committees. The Western North Dakota Health Systems Agency is responsible for coordinating and establishing health planning activities in a large geographic area - some 40,000 square miles. Because of this large area, a disproportionately large percentage of the Agency's budget must be allocated to travel expenses, both for Board, committees, and staff. Presently, the establishment of Subarea Advisory Councils remains a financial impossibility.

The Western North Dakota Health Systems Agency has determined that, in order to adequately achieve the objectives and functions which are required under Public Law 93-641, a minimum allocation of \$275,000 would be required.

The Agency is perpetually hampered in its functions by severe climatic variations, less than optimal roads, in some instances, and the vast geographic region to be covered. Additionally, much of the health service area is experiencing major energy impact and population increases.

Although operating under the aforementioned restraints, the Western North Dakota Health Systems Agency has experienced positive results through its planning efforts.

In addition to successful accomplishment of mandated functions, the Agency has been involved in the following improvements. Through efforts of the Western North Dakota Health Systems Agency, a regionwide Remote Cardiac Monitoring System was established, tying in a central facility with five rural outlying hospitals. Thus, continuous cardiac monitoring can now be accomplished in a much more accessible mode, while reflecting major cost savings.

Through coordination efforts of the Western North Dakota Health Systems Agency, a rural community was provided with a Canadian physician, who, because of immigration restrictions, was barred from immediate entry.

The Western North Dakota Health Systems Agency has been intimately involved in the establishment of rural satellite clinic systems, increasing rural accessibility to medical care while extending the role of the scarce medical manpower within the area. In relation to this function, the Agency has been instrumental in the placement of four Public Health Service Dentists and two physicians through the National Health Service Corps.

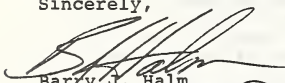
A Poison Information and Treatment network has been established, at the Agency's insistence, to provide rapid detection and treatment capabilities and providing identifiable linkages to a tertiary center and clinical toxicologist.

The Agency regularly sponsors and presents regionwide public conferences, dealing with issues such as Medical Manpower Recruitment.

Finally, through its review functions, the Agency estimates a savings to its area of in excess of 2 million dollars through discouragement, alteration, or denial of unnecessary health expenditures, a substantial amount for a rural area.

The Agency wishes to continue and expand the impact which it has had within the area of western North Dakota. To accomplish this task, a minimum funding level of \$275,000, as stated earlier, would be required.

Sincerely,

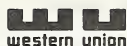
  
 Barry J. Halm  
 Executive Director

  
 Richard P. Spilovoy  
 Deputy Director

BJH/RPS/blc



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DOROTHY D MOSKIN, PRESIDENT  
WESTERN COLORADO HEALTH SYSTEMS AGENCY BOARD  
OF DIRECTORS  
2525 NORTH 7TH ST  
GRAND JUNCTION CO 81501

WE AGREE WITH THE POSITION AS OUTLINED IN THE POSITION PAPER FROM YOUR  
AGENCY DATED 1-23-78. OUR AGENCY IS EFFECTED BY DIFFICULT TERRAIN,  
ADVERSE WEATHER CONDITIONS AND LIMITED TRANSPORTATION NETWORKS.

COPY OF THE 1976-77 ANNUAL REPORT WHICH INCLUDES LISTING OF COMMITTEE  
ACCOMPLISHMENTS AND PROJECTS REVIEWED IS BEING SENT UNDER SEPARATE  
COVER

MISS MARY STURM (1144 WEST CHURCH ST FREDERICK MD 21701 301-662-8266)  
AND MRS AGNES KEMERER (FREDERICK COMMUNITY COLLEGE ROUTE 9 FREDERICK MD  
21701 301-662-0101) IF NEEDED ARE WILLING TO TESTIFY IF GIVEN ADEQUATE  
NOTIFICATION

STERLING E BOLLINGER SR, PRESIDENT  
HEALTH SYSTEMS AGENCY OF WESTERN MARYLAND  
134 NORTH MECHANIC ST  
CUMBERLAND MD 21502

13:21 EST

MGMCOMP MGM

TELEGRAM PHONED TO DOROTHY HOSKIN, PRESIDENT, BOARD OF DIRECTORS  
WESTERN COLORADO HEALTH SYSTEMS AGENCY, GRAND JUNCTION, COLORADO  
ON FEBRUARY 1. 1978.

MERRIMACK VALLEY HEALTH PLANNING COUNCIL SUPPORT POSITION PAPER  
OF "MINIMALLY FUNDED AND RURAL HSAS," PARTICULARLY FOR MINIMUM  
FUNDING AT THE LEVEL OF \$275,000 TO EFFECTIVELY ACCOMPLISH ALL  
AGENCY FUNCTIONS.

WILLIAM SLUSHER, CHAIRMAN

MERRIMACK VALLEY HEALTH PLANNING COUNCIL

120 PARKER STREET

LAWRENCE, MASSACHUSETTS 01843

DJLM

GRAND JCTN AGT

853AM

DVB317(1721)(1-019010A030) PD 01/30/78 1720

ICS IPMAFUB AHG

073 A 13008 NL KETCHIKAN ALASKA 64 01-30 140P PST

~~PMS DOROTHY D HOSKIN PRES W2STERN COLORADO HSA-245-3590~~

2525 NORTH 7 ST

GRAND JUNCTION CO 81501

I APPRECIATE AND SUPPORT YOUR EFFORTS TO PROMOTE HSA  
FUNDING INCREASES. SOUTHEAST ALASKA HEALTH SYSTEMS AGENCY  
HAS ADOPTED AN EXTENSIVE FIVE YEAR HEALTH SYSTEMS PLAN,  
IMPLEMENTED A HOSPITAL CARE STUDY INVOLVING ALL SOUTHEAST  
ALASKA HOSPITALS FOR PURPOSES OF COST CONTAINMENT,  
DEVELOPED PROJECT REVIEW AND SYSTEMS DEVELOPMENT IMPLEMENTATION  
STRATEGIES ETC. WE NEED 1640 DEVELOPMENTAL FUND MONIES AND  
LARGER FEDERAL GRANT FOR FULL DESIGNATIONS.

HOWARD GABRIEL EXEC DIR SOUTHEAST ALASKA HEALTH SYSTEMS AGY



HEALTH PLANNING COUNCIL OF THE EASTERN SHORE  
P.O. BOX 776, CAMBRIDGE, MD. 21613 301/228-8911

Janaury 30, 1978

RECEIVED FEB 1 1978

CAROLINE

CECIL

DOUGLASS

KENT

QUINCY

SOMERSET

Ms. Dorothy D. Hoskin, President  
Western Colorado Health Systems Agency  
2525 N. 7th Street  
Grand Junction, Colorado 81501

Dear Ms. Hoskin:

By this letter I would like to indicate my support of the position paper of minimally funded and rural health systems agencies.

Since our agency and others like it are responsible for the same number of functions under the law as large, well financed agencies, we feel at a definite disadvantage. We request that the minimum funding level be raised in the future. The formula used for federal matching of local dollars supporting the Health Planning Program also discriminates against the agency funded at the minimum level. Although our Council attracted about \$50,000 in state and local government funding during our first year of designation, this high level of local participation did not qualify our agency for any federal matching money. We also request changes in the formula for providing federal matching money to make it available to all Health Systems Agencies.

I very much appreciate your efforts to obtain more resources for agencies such as ours, and trust that those efforts will be successful.

Yours truly,

Robert J. Allen, President  
Health Planning Council of the  
Eastern Shore, Inc.

RJA:dc

TALBOT

WICOMICO

WORCESTER



Telegram

LLA120 WAG130(1353)(4-037714E031)PD 01/31/78 1353

1978 JAN 31 PH 2:00

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PMS DAVE MEYER, RDM REPORT DELIVERY BY MAILGRAM FONE AND DLR

330PM 2/1/78, DLR

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WASHINGTON DC 20000

THE WEST CENTRAL OHIO HEALTH SYSTEMS AGENCY STRONGLY SUPPORTS THE  
 "POSITION PAPER OF MINIMALLY FUNDED AND RURAL HEALTH SYSTEM  
 AGENCIES" AND FEELS THAT THE ISSUES ADDRESSED WITHIN THIS PAPER ARE  
 OF CRITICAL IMPORTANCE TO AGENCIES SUCH AS OURS.

NELSON C COOK EXECUTIVE DIRECTOR WEST CENTRAL OHIO HEALTH  
 SYSTEMS AGENCY LIMA OH (616 SOUTH COLLETT LIMA OH 45805)

NNNN



**CENTRAL  
MINNESOTA  
HEALTH  
SYSTEMS  
AGENCY**

**RECEIVED FFR 2 1978**

January 31, 1978

Dorothy D. Hoskin, President  
Western Colorado Health Systems Agency  
Board of Directors  
2525 North 7th Street  
Grand Junction, Colorado 81501

Dear Ms. Hoskin:

The Central Minnesota Health Systems Agency is generally supportive of the concepts as presented in the position paper entitled "Minimally Funded and Rural Health Systems Agencies". I would personally be hesitant to support the minimal funding level of \$275,000 based upon the experience of our own Health Systems Agency.

The Central Minnesota Health Systems Agency's specific problems would be those which relate to weather and lengthy travel distances. Both of the above mentioned areas have effected participation, because of the number of meetings and travel time involved, which in our region in some cases, means a whole day commitment for a 2-3 hour meeting.

The Agency despite the problems sited has experienced successes which include:

1. The adoption of a HSP which includes 14 specific components in the health system;
2. The development of review criteria, and the continued conduct of reviews under Certificate of Need and Section 1122. During the past 18 months the Agency has conducted reviews on projects valued at \$28,685,607.60. In addition the Agency conducted a cost over-run study, which indicated that the estimated costs proposed were in fact extremely lower than actual costs;
3. The provision of technical assistance to approximately 30 different agencies, including Community Health Service Agencies, hospitals,

- continued

Benton  
Cass  
Chisago

Crow Wing  
Isanti  
Kanabec  
Mille Lacs

**2625 Clearwater Road • St. Cloud, Minn. 56301**  
**(612) 253-2930**

Morrison  
Pine  
Sherburne  
Stearns

Todd  
Wadena  
Wright

and individual communities; and

4. The continued coordination of planning activities on both a statewide level, and Health Service Area level.

Sincerely,

*Sister Luke Hoschette*  
Sister Luke Hoschette (SL)  
Chairman Pro tem

SLH:cls

xc: Western Maryland Health Systems Agency

Health Planning Association of Western  
Kansas Board of Directors

RECEIVED FEB 6 1978

## LAKE WINNEBAGO AREA HEALTH SYSTEMS AGENCY



404 N. Main Street - Suite 140  
Phone (414) 231-2907  
Oshkosh, Wisconsin 54901

February 3, 1978

Dorothy D. Hoskin, President  
Western Colorado Health Systems Agency  
Board of Directors  
2525 North Seventh Street  
Grand Junction, CO 81501

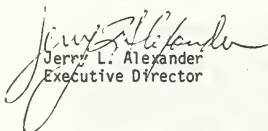
Dear Ms. Hoskin:

I regret that I was not able to reply to you by your deadline date. I wanted to discuss the matter with the Agency's President, which caused some delay. If it is of any use to you at this point or if you can still communicate this information to the subcommittees you may have met with, please feel free to do so.

The President of the Agency agrees in principle with the intent of the position paper. The agreement, with the intent of the position paper, supports the need for recognition of unique problems faced by rural HSAs and the need for increased funding for minimally funded and rural HSAs.

If you have the time, I would be interested in knowing what your reactions are to your meeting in Washington and your anticipation of possible changes in the health planning law.

Respectfully,



Jerry L. Alexander  
Executive Director

JLA:dm

cc: Carl Steffin, Agency President  
Benjamin Patch, Executive Director  
Southern Maryland HSA

## EASTERN WASHINGTON HEALTH SYSTEMS AGENCY

WEST 1728 JACKSON AVENUE  
SPOKANE, WASHINGTON 99205  
PHONE (509) 456-3178

RECEIVED... 3 1978

February 1, 1978

Dorothy D. Hoskin, President  
Western Colorado Health Systems Agency  
Board of Directors  
2525 N. 7th Street  
Grand Junction, CO 81501

Dear Ms. Hoskins:

I have reviewed the position paper of the Minimally Funded and Rural Health Systems Agencies.

I concur with the content of this position paper and I am in support of the premise that the minimum level for minimum funded and rural HSAs must be increased if these agencies are to accomplish all that PL 93-641 intends.

In the Eastern Washington Health Systems Agency, we have a number of unique problems which make the present funding level inadequate for our needs.

1. EWSHA is a public regional agency. In addition to the operational Governing Body we have a Regional Board comprised primarily of County Commissioners. Assuring adequate communication to the public regional and achieving consensus on documents such as: personnel policies, budget, and bylaw changes requires that we devote considerable staff resources. Most other HSAs are not public regional agencies and thus do not have this requirement for additional staff support.
2. EWSHA is an agency with 5 strong Subarea Councils, each with high expectations of grass roots involvement in all matters of the HSA. To meet these expectations it is necessary that we maintain regional offices and devote a high percentage of staff resources to Subarea Council management. With minimum staffing levels the priority of Subarea Council management and Health Systems Plan Development are frequently in competition. DHEW insists that development of the plan is to be our primary emphasis and our citizens and volunteers insist that there must be a strong local organizational component to influence HSA Plan Development. We have resolved the issue temporarily by doing both functions but at the possible expense of staff and volunteer "burnout" from over commitment and overwork.
3. EWSHA was funded in September 1976, but did not have a full staff complement until April of 1977. With no legacy of plan documents from CHP and getting a late start, EWSHA has had to accelerate at a tremendous pace. In recognition that our staff resources were too limited to accomplish all that, DHEW expected we turned to CETA funding for assistance. Fortunately we received approval for 3 professional and 1 support staff position. We have utilized these staff as: a Plan Development Assistant, a Community Relations Assistant, a Graphics-Data Management Assistant and a Secretary. The EWSHA with a late start and inadequate funding has caught up and is now on schedule for Plan Development and other required tasks.

4. We have reviewed several substantial Certificate of Need applications that have required many man-months for analysis. The agency recently reviewed a \$20 million hospital replacement project and recommended reduction in number of surgeries in the project. The agency has also saved the community money by recommending against a nursing home lease that was unnecessarily high.

On January 24, 1978, the Region X Association of Presidents and Executive Directors adopted a position to support that portion of the Senate Bill which provides for \$250,000 for minimally funded, minimally staffed HSAs, plus \$.70 per capita.

While it is evident to us that minimally funded agencies have inadequate financial resource, we would not like to see increased funding for minimally funded and rural HSAs at the expense of the larger urban HSAs.

I trust these comments are useful to you.

Sincerely,

*Bob Sheffels by DCS.*

Robert Sheffels  
Chairman

cc: Richard L. Brownrigg, M.D.  
Vernon Marll  
Western Colorado HSA  
Western North Dakota HSA  
Region X HSAs  
Governing Body Members

RS:DCS:cb



RECEIVED FEB 2 1978

## West Tennessee Health Improvement Association, Inc.

804 Highway 46 Bypass, Watkins Towers, Suite 304  
Jackson, Tennessee 38201  
(615) 665-5228

G.M. McClellan, M.D.  
President

Ronald F. Reid  
Executive Director



January 27, 1978

Ms. Dorothy D. Hoskin, President  
Western Colorado Health Systems Agency  
Board of Directors  
2525 N. 7th Street  
Grand Junction, CO 81501

Dear Ms. Hoskin:

The West Tennessee Health Improvement Association gives its full support to the Minimally Funded and Rural Health Systems Agencies' concepts as presented in the Position Paper. The West Tennessee Health Improvement Association has actively supported the efforts of this group to present to Congress the problems faced by small agencies.

Our Health Systems Agency has operated over the past 20 months in an area which covers 8,437 square miles and includes 17 counties in Rural West Tennessee. Since the 421,800 population of Rural West Tennessee is projected to increase moderately in all 17 counties of the area through 1990, there is expected to be an increasing demand for health services through that year.

As our health service area is characterized by gently sloping uplands and river bottoms, transportation for health care is not seriously impeded by geographical obstacles. However, the distribution of the rural population, lack of major urban centers, and often inadequate secondary roads result in difficulty in reaching health care, and long response times for emergency medical services. Adequate public transportation is generally unavailable to most of the population, so that heavy reliance is placed on private automobiles.

Rural West Tennessee has a higher proportion of elderly persons and a lower proportion of young persons than does the State of Tennessee as a whole. This places a heavy burden on the health system as elderly persons usually require more health services than young persons.

Also, unemployment and poverty tend to be more prevalent in Rural West Tennessee than in the State as a whole. Both factors tend to be closely related to poor health. Although over-crowded housing is not a major problem, Rural West Tennessee has a greater proportion of housing without proper facilities, such as plumbing and kitchen facilities, than does the State as a whole. This may lead to degradation of local water quality, a greater incidence of disease, and poor nutrition. Finally, the educational achievement in the area is below state and national norms. This may lead to inadequate knowledge of good health practices and difficulty in obtaining medical care.

All of these factors provide a great challenge to the West Tennessee Health Improvement Association in accomplishing the myraid of tasks required. Specifically, the involvement of area consumers, providers, local elected officials and limited professional staff in planning to overcome these problems is curtailed by insufficient travel and public involvement monies. Board and Committee involvement, a commitment to "bottoms up" planning and adequate opportunity for review and comment by interested parties demand sufficient funding and extensive meeting and hearing schedules. This cannot be accomplished when travel funds must be secondary to maintaining Agency operations.

Despite the constraints and obstacles mentioned above, the West Tennessee Health Improvement Association has been able to bring about a number of significant achievements which are already having a positive impact on health care in the area.

1. Major economies in health care costs have been effected through an active project review component, which is placing a high priority on cost containment. To date, approximately one out of three applications for capital expenditures by health facilities have been recommended for disapproval under the state Certificate of Need program. These recommendations concerning unnecessary or duplicative expenditures involved \$6,694,000 in capital expenditures and 436 intermediate care beds recommended for disapproval. In addition, the Agency has developed procedures and criteria for greatly increased cost containment impact through review and approval/disapproval of Federal health funds and appropriateness reviews. Authority for conducting such reviews has been applied for from the Dept. of Health, Education, and Welfare and is expected by April.

2. Although the Agency's Annual Implementation Plan will not become fully effective until April, almost all actions contained in that document, as well as many actions in the long-range Health Systems Plan, are already underway. In addition, nine major actions have already been successfully accomplished. These include:


- a. Comprehensive child health program in Madison, Haywood, and Hardeman counties.
- b. WIC nutritional program in Benton, Carroll, Gibson, and Crockett counties.
- c. Child health project in Henderson County (the only such program in West Tennessee).
- d. Program to reach alcoholics in the black community.
- e. Juvenile education program for alcohol and drug offenders.
- f. Supplemental nutrition program in five counties.
- g. Legislation allowing Medicare reimbursement of physician extenders.
- h. Procedures and criteria for allocation of modernization and construction funds.
- i. Homemaker program in Chester, Madison, and McNairy counties.

Other major actions now underway with agency backing or cooperation include physician recruitment (two additional physicians have already been successfully obtained), establishment of rural primary care clinics through the Rural

Health Initiative Program, expansion of home health care as an alternative to expensive institutionalization, and promotion of boarding home licensure. Thirty-five similar actions are well on their way to accomplishment.

The Agency has also convened a High Level Wellness Task Force to promote the principles of preventive medicine and raise the overall level of health of the population. The efforts of the Task Force have met with outstanding results and generated exceptional response in the community. The Agency was instrumental in obtaining designation of a portion of the health service area as shortage area for placement of health manpower, and is currently engaged in effecting a similar designation for another area. Finally, the West Tennessee Health Improvement Association enjoys an exceptional degree of acceptance and involvement in the community, including both consumers and providers of health care.

Respectfully submitted,

  
O. M. McCallum, M.D.  
President

da

RECEIVED FEB 6 1978



# Western Oregon Health Systems Agency

975 Oak Street, Suite 320 • Eugene, Oregon 97401 • 503/484-9311

February 2, 1978

Dorothy D. Hoskin, President  
Western Colorado HSA  
Board of Directors  
2525 E. 7th Street  
Grand Junction, CO 81501

Dear Ms. Hoskin:

Recognizing that there is an urgent need for increased funding for minimally funded health systems agencies without adversely affecting the funding of larger agencies, the Region X Association of Health Systems Agency Presidents and Executive Directors unanimously adopted the following position statement at its January 27-28, 1978 meeting:

The Region X Association of HSA Presidents and Executive Directors hereby supports that part of Sec. 129(c)(3) of S. 2410, the Health Planning Amendments of 1978, introduced by Senator Kennedy on January 23, 1978 which states: "(c) Section 1516(b)(3) is amended to read as follows: (3) The amount of a grant under Subsection (a) to a health systems agency...may not be less than \$250,000 in the fiscal year ending September 30, 1979...."

In addition the Association feels that this amount should, in fact, be a minimum and that local monies raised by minimally funded agencies should be entitled to Federal matching funds.

We hope you will support this position. Please contact me if further clarification is desired.

Sincerely,

Spencer D. Ralston, President  
Region X Association of HSA  
Presidents and Executive Directors

SDR:gp

Executive Director  
Spencer D. Ralston

Board of Directors  
President  
Jan L. Timm  
Sno

Vice-President  
Richard C. Williams  
Eugene

Secretary  
Zella M. Every  
Corvallis

Treasurer  
David L. White, M.D.  
Eugene

Gene Bailey  
North Bend

Rosemary Batoni  
Eugene

Daniel Boals, M.D.  
Medford

Ruth Carney  
Dufur

Dale Curry, R.Ph.  
Sisters

Gary Edwards  
Hood River

Joseph Ferry  
Boardman

Aaron Garber  
Eugene

Larry Gaustina  
Eugene

MacLane Hill  
Astoria

Larry Hixson, M.D.  
Eugene

Antonio Iannarone  
Medford

Harry Leiby  
Bend

Lois McCallister  
Laurel

Mary Alice Muncy  
Corvallis

Theresa Nugent  
Eugene

George Olsson, D.D.S.  
Julesburg

Margaret Patone  
Eugene

John Perkins, O.D.  
Eugene

Austin Pilcher  
Eugene

Edward Sypher  
North Bend

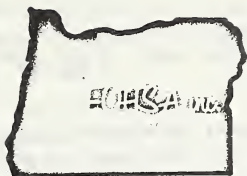
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Clatsop Pass

Lester Williams  
Bend

Mary Wiles, R.N.  
Yreka

Arletta Wood, R.N.  
Astoria

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1037 N. Sixth Street Redmond, Oregon 97756  
Telephone (503) 548-5185

January 30, 1978

Dorothy D. Hoskins, President  
Western Colorado Health Systems Agency  
Board of Directors  
2525 North 7th Street  
Grand Junction, Colorado 81501

Dear Ms. Hoskins;

This is a letter in support of the position paper on minimally funded rural health system agencies. Our health system agency and many of the health system agencies in Region X, HEW (Alaska, Washington, Oregon and Idaho) are minimally funded health system agencies with extraordinary time/distance problems. The travel problems resulting from our large health service areas and small population densities creates special problems for us in carrying out the requirements and intent of P.L. 93-641. Our agency, Eastern Oregon Health Systems Agency, Inc., encompasses a land mass of more than 68,000 square miles with a population of approximately 3000,000 people. It is readily apparent that our communities are widely spaced when one looks at the map of Oregon. Our HSA covers an area larger than the whole state of Washington. No community is larger than 16,500 people which means we have a great number of small communities spread out over our health service area.

The size of our health service area and our minimum funding status of \$175,000 has placed a substantial burden on our Agency in carrying out the functions prescribed by HEW. A specific example of one of those problems is that convening our Board, necessary committees and providing them with the necessary staff support requires that our travel budget be large. As a matter of fact our travel budget represents 25.1% of our total budget. This has placed an inordinate amount of our funds in the category of "travel" which effectively robs funds that could be used for additional personnel. We have six (6) staff persons. Four (4) are responsible for agency management and carrying out professional planning and review responsibilities and two staff persons providing secretarial and administrative support. We feel that to expect our health systems agency to perform within the same time frame and produce the same products that other agencies with considerably higher funding levels is unrealistic and results in inappropriate expectations. In addition, there were no predecessor comprehensive

President  
James H. Carlson  
Vice-President  
Jene Kirkpatrick, A.C.S.W.  
Secretary  
Karen B. Kaseberg  
Treasurer  
Dave Hoerning

## MEMBERS BY GEOGRAPHIC AREA

Baker  
George Nicolascu  
Burns, Paiute Tribe  
Kanton Dick  
Umatilla and Warm Springs Tribes  
Emma Farrow  
Crook  
John H. Sey, D.M.D.  
Deschutes  
Dave Hoerning  
Jene Kirkpatrick, A.C.S.W.  
Don O. Schuman, O.D.  
Gilliam  
Foster Odom  
Grant  
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Dale White  
Humboldt  
Jerry Roulston  
Jellicson  
Herschel Reed  
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Veldon C. Boge, M.D.  
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Sherman  
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Umatilla  
Harold Delamarter  
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Michael Fraser  
Union  
Grace Brothers  
Daniel Kehr, D.C.  
Walla Walla  
Lidija O. Crane  
Wasco  
Robert L. Proffitt  
Ralph M. Stearns  
Wheeler  
Kenne Sheen, R.N.



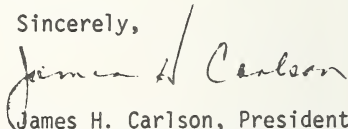
health planning agencies in our health service area prior to Public Law 93-641 and the concept of a regional, comprehensive health planning is one that takes time, great care and delicacy to sell.

In terms of innumerating specific successes of our Agency we feel that the very fact that we have a health system agency organized with nine (9) subarea health planning councils actively participating with us is no small success in itself. Between the 30 persons on our Board and an additional 215 or so subarea health planning council members and probably another 100 or 200 individuals who are working closely with the local health planning councils and our Board, we feel that we have a very strong, active, committed nucleus. They are adopting the concept that looking at our health care problems and needs in a systematic, rational and thorough manner will benefit the citizens they represent. We believe that we have quite strong relationships with our 18 county courts or commissions as well as with the health care institutions in our health service area. We have completed our health system plan, are moving towards the completion of our annual implementation plan and expect to begin to do selected project and Certificate of Need reviews within the next two months.

We feel strongly that if this very delicate and fragile mechanism for improving the health of citizens is to succeed we must have sufficient resources. We are encouraged by the effort of Board and staff members from the minimally funded rural HSAs coalescing around the unique problems but exciting potentials of the minimally funded and rural HSAs.

Our Board of Directors have not met as a body to discuss this position paper but on behalf of the Board, I believe that the principals stated in the position paper reflect our Board's concerns and expectations about the role of our health systems agencies and the necessary resource support for them. I can not supply you with names of Board members who are able and willing to testify before committee hearings but will try to determine their availability when we meet as a Board. Thank you very much for your initiative and commitment to represent us at the hearings scheduled in Washington. If there are any questions or concerns that you have or any request for additional information, please don't hesitate to contact us at: Eastern Oregon Health Systems Agency, 1037 North 6th, Redmond, Oregon 97756, or telephone area code 503 548-5185.

Sincerely,



James H. Carlson, President  
Eastern Oregon Health Systems  
Agency

cc: Richard L. Brownrigg, M.D.  
President, Health Planning  
Association of Western Kansas

RECEIVED FEB 3 1978

134 North Mechanic Street  
Cumberland, Maryland 21502

Phone 301-724-1616

January 30, 1978

(Confirming Mailgram)

Dorothy D. Hoskin, President  
Western Colorado Health Systems Agency  
Board of Directors  
2525 N. 7th Street  
Grand Junction, CO 81501

Richard L. Brownrigg, M.D., President  
Health Planning Association of  
Western Kansas Board of Directors  
1010 East Seventeenth Street  
Hays, Kansas 67601

We agree with the position as outlined in the position paper from your agency dated 1/23/78. Our agency is effected by difficult terrain, adverse weather conditions and limited transportation networks.

A copy of the 1976-77 Annual Report which includes listing of Committee accomplishments and projects reviewed is being sent under separate cover.

Miss Mary Storm (114A W. Church St., Frederick, Md. 21701 301-662-8266) and Mrs. Agnes Kemerer (Frederick Community College, Rt. 10, Frederick, Md. 21701 301-662-0101) if needed are willing to testify if given adequate notification.

Sincerely,

*Sterling E. Bollinger, Sr.*  
Sterling E. Bollinger, Sr., President  
Health Systems Agency of Western Maryland  
Governing Board

cc:

Senator Charles McC. Mathias, Jr.  
Senator Paul Sarbanes  
Representative Goodloe Byron  
Miss Mary Storm, Governing Body  
Mrs. Agnes Kemerer, Governing Body

## STATEMENT OF RICHARD NEIBAUR

Mr. NEIBAUR. Mr. Chairman, Mr. Carter.

My name is Richard Neibaur. I am here in the capacity as the chairman of an organization which is made up of the executives and staff of the single HSA States, the members of their boards of directors, the members of the State health planning agencies, and the State health coordinating councils.

We are a group of people who kind of got together at a meeting last year, called to discuss the "problem of the single agency State HSA's".

There are 14 single State HSA's. Whether or not the law and the law makers anticipated this would happen, it has. We are trying to get on with it.

We are in somewhat the same situation as my colleagues from Colorado and the western coast here. We are basically the big rural States less than a million population, generally. My own State of Wyoming has a population of less than 400,000 and an area of nearly 100,000 square miles. Their special problems are certainly mine as well.

We are a single State HSA, which is minimally funded, as well, so I can sympathize with all of their problems. The message I would like to bring to the members of the committee primarily is we, in the single State situation, are viable. We saw that we were kind of the stepchildren of this law, and we are all committed to the idea of citizen participation planning, that we can best solve our own problems with our own people, our own ideas and a little bit of help from the Feds, primarily some money, but we saw that we were threatened, that the single State HSA's, as you have seen in testimony—I am sure you have been told before—is so duplicative as to be obstructive of the intent of the law.

I submit that Congress is duplicative—it has two houses, they are called checks and balances. They have instituted certain kinds of duplication in this law. We have State agencies and we have single State HSA's and there is invariably going to be some constructive conflict.

There are a lot of different ways to design and operate a health system, and I don't think anybody has come up with the one way of doing it yet, whether it be HSA, State agency, certainly not the Federal Government.

My plea is that you maintain kind of a status quo. Let us get on with it. Let us move the single State option, whatever it be, as a viable way of implementing the intent of the law.

I have submitted written testimony to your staff, and I appreciate the opportunity to come here and speak before you.

[Testimony resumes on p. 1160.]

[Mr. Neibaur's prepared statement follows:]

TESTIMONY BEFORE  
The Subcommittee on Health and the Environment  
of the  
House Interstate & Foreign Commerce Committee  
Paul G. Rogers of Florida, Chairman

By  
Richard Neibaur, Chairman.  
National Association of Single State Agencies

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Briefly, the National Association of Single State Agencies is an organization of the staffs and the members of the governing bodies of the various entities created by Public Law 93-641; that is, staff and members of the health systems agencies, members of the State Health Coordinating Councils and staff of the State Health Planning and Development Agencies. The purposes of the Association, as stated in the corporate charter and Bylaws are: a) the development of position papers regarding planning and single agency states; b) the sharing of information regarding plan development and plan implementation within the several single agency states; c) organizing efforts to influence various professional organizations to which the members belong; d) to make elected officials of the several states aware of the common position adopted by the members;; and e) to promote the understanding of the position and problems which confront the single state agency in implementation of Public Law 93-641 among political bodies at a local, state, and national level.

As can be seen, the purposes are to promote the planning concept in single HSA states and to enhance planning through our joint efforts to assist one another in implementing the Act. The



organizers believe that the single HSA in a state is the best way to insure consumer-provider participation in the health planning and resource development decision arena and are dedicated to that proposition. We share many common concerns regarding the Department of Health, Education, and Welfare's apparent inability to cope with the anomalous situation of a single health systems agency in a state.

There are 13 states in which there is a single health service area and thus a single HSA. This also applies to Puerto Rico. For the most part, the states are rural in nature and have moderate to very small populations. My own state, Wyoming, of which I am the Director of the single HSA, might be cited as an example of why there are single state HSAs. Wyoming has a population of under 400,000 and an area of nearly 100,000 square miles.

There is no question that there are a number of problems with Titles 15 and 16 of the Public Health Service Act. The Subcommittee has heard and will continue to hear, witness after witness from agencies, groups, and the Administration telling all about these problems, and advising you on what it is that you should do to rectify the Law.

I will limit my comments to the issues which are more pertinent to the single agency states and leave it to the others to advise and inform you on the other issues.



There are three areas which I will direct my comments toward: 1) the relationships between the various entities created by Public Law 93-641 in the Single HSA States; 2) the National Health Planning Guidelines; and 3) the funding of agencies in Single HSA States.

While there certainly are problems with regard to the interrelationships of the various entities in the typical multi-HSA state, there are quite a different set in those HSAs which cover an entire state. Although the problems are different, the cause of them is the same. That cause is what makes this country what it is - diversity. The greatest mistake which Congress can make is to spell out in statute how states must conduct their internal affairs. The broad outlines of our state governments are those provided by the Constitution of the United States. Separation of powers, a bicameral legislature, the structure of the court system and other common features are shared by nearly all states, but there the similarity ends. Every state has for a variety of reasons, arranged its internal administration differently. Therefore, in implementing Public Law 93-641, there are nearly as many models as there are states.

The interface and relationship between private non-profit planning organizations (HSAs) and the administrative structure of the State's Executive Branch are new ones in many cases, particularly when the non-governmental entity has some original power, and is not purely advisory. In some states, this relation-

ship has been a very strained and tense one, whereas in others, it has gone very well.

Public Law 93-641 introduced an alternative set of organization and organizational relationships with one purpose - to implement the purposes of the Act. New organization and inter-organizational relationships were created because those which existed previously were not capable of implementing the desires of Congress. Anything new suddenly inserted into the organizational environment, as Health Systems Agencies were, is bound to create problems. These problems need to be worked out by the people involved in each state, in such a way as to fit each state's unique situation. Accommodation will be reached in which hopefully the intent of the Act will be carried out. These accommodations will be different in nearly every case because they will reflect the organizational and political realities of the individual states.

Congress, in its wisdom, did not dictate how the entities were to interrelate. It said that they would in certain areas, and left the "how" up to the local people. The problem with the implementation of the Law is that the Administration is not as acutely aware of the diversity in the country as is Congress.

Regulation promulgated by DHEW under the authority of P.L. 93-641 reflects a desire to standardize the administration and implementation of the Law, and to force the several states and the two hundred plus HSAs into the same mold. Now, there

is no question that it would greatly simplify the administration of the Law, if all agencies (state and local) were the same, and they all had identical working relationships with one another. There are, unfortunately, people on both sides of the Law, in DHEW and in the agencies, who want a "cookbook" approach. Disasterously, there are people in DHEW who feel perfectly comfortable in writing the cookbook and people in the agencies perfectly comfortable in following it.

The history of the Act since its passage has been rather rough, with long delays in guidance from DHEW, and a conflict between DHEW and Congress over the intent of the Law. Conflict and delays which have, in my opinion, given ammunition to those who on the one hand do not want consumer participation in health planning, and on the other who want a total takeover of health care by the Federal government.

The conflict and the delays have been due largely to the desire on the part of DHEW to "standardize" the entire country for the purposes of Health Planning and Resource Development. It seems that the people charged with the administration of the Law at a national level don't understand that this is not a homogeneous nation and that some broad guidelines and then some common sense will go much farther toward achieving the goals than organizing the planning efforts by prescription.

In the general absence of help from the national level,

each of the States and their HSA (whether multiple or single) have worked out mutually acceptable accommodations. Some of the accommodations may seem to be in conflict with the Law, but before you tinker, or permit DHEW to tinker, with the relationships which have been established, give them a chance.

There are those both from the Administration and elsewhere who will tell you that as currently constituted, there is no way in which HSAs can effectively plan, and that all manner of changes are necessary. I urge you to leave in the flexibility, which is in the Law, and to discourage the Administration from standardizing our organizations by regulations and guidelines.

The Single State Agency is one which is most vulnerable to tinkering. It has been variously suggested that Congress never anticipated the single HSA in a state and that it was anticipated that Section 1536 would take care of any that developed.

I would like to direct the Subcommittee's attention to a report which was distributed earlier this week, "Study of Single HSA States and Section 1536 States," by Arthur D. Little, Inc. for the Bureau of Health Planning and Resource Development, H.R.A., DHEW Contract HRA 230-76-0212. In this report, which grew out of contract teams spending several days in each of the Single HSA States and 1536 states, are a number of recommendations for action by DHEW or Congress to make the Single State HSA and the 1536 state more viable. I would like to cite for the Subcommittee's benefit the first recommendation.

"BHPRD should preserve the statewide HSA option and issue a policy statement in the form of a Program Policy Notice recognizing its validity, uniqueness, and needs."

The single HSA structure is workable within the context of P.L. 93-641 and DHEW should recognize it as a legitimate health planning structure. Neither the majority of the states themselves nor the Arthur D. Little, Inc. study team experienced the problems and circumstances associated with this structure as debilitating; the few unique issues associated with the structure appear resolvable with guidance and clarification from DHEW. Furthermore, an official affirmation of the structure's validity would be useful at this time. Many of the states operating under this structure feel "illegitimate" for at least two reasons: (1) The single HSA structure is mentioned in law and legislative history, but is not operationally addressed in the legislation or implementing regulations; and (2) There is currently much debate on a national level as to the merits of the single HSA structure. Our experience suggests the debate to be warranted only as an aspect of the broad national debate about who is to control the health care industry. So far as this particular structural option is concerned, DHEW should issue a policy statement recognizing the validity of the structure and declaring departmental intention to develop guidance for and/or provide technical assistance to single HSA states in those functional and structural areas where uncertainties or problems remain."



My comments above regarding the move to standardize the organizational form and interrelationship of HSAs, SHPDAs, and SHCCs are just as applicable to the development and promulgation of the "National Guidelines for Health Planning."

I have always interpreted guidelines to represent one view of the best way to get from point "A" to point "B". Even if that view is widely held, if someone comes up with another route from point "A" to point "B", it should be given a hearing; and even though it violates the original guidelines but gets you to your goal, Point "B", without interfering with the achievement of other goals, and is more practical or economical, the guidelines should be changed.

There is no question but what we need some National Guidelines which express national policy positions on health planning. The health systems agencies and the SHPDAs need some anchors to resist some of the overwhelming pressures which can be generated by emotional issues in some communities. Witness the current situation with the Oral Robert's University Hospital and Medical Center, a proposed seven hundred seventy seven bed teaching hospital in Tulsa, Oklahoma. The anchors must come with a long enough rope that they will provide stability without pulling us under. The revised "proposed" guidelines published on January 20, 1978 reflect the somewhat lengthened rope to which I refer. When first issued, the proposed guidelines did not draw much fire. Unfortunately, the way in which they were

promulgated, the emphasis on only one priority and the again "Standardization" approach tended to cast serious doubt on their value, if not their legitimacy. These questions all came to the fore in November when the ire of Congress was expressed to the Secretary of DHEW.

I believe the message of these recent events should be clear to Congress, you cannot give too much discretion to the Administration in interpreting your policy direction.

Those of us in the field trying to implement this piece of legislation have seen time and again interpretation by the bureaucracy which do not seem to be consistent with the apparent intent of Congress, or artificial impediments to the implementation of the Law created by DHEW.

Part of the fault surely lies with Congress in that too much discretion was given the "Secretary" in interpreting the Act. In many cases, that "Secretary" is in reality some mid-level bureaucrat. An early evaluation of the Act forecast the troubles which have developed based simply on a count of the number of times the term "the Secretary shall" or "the Secretary may" appeared.

The final point which I would like to bring to your attention is not entirely one peculiar to the Single HSA States. Funding is always a problem, there is never enough to do the job,

no one hears that lament more than members of Congress. In truth, the authorization level and appropriations for the Health Planning and Resource Development are not appropriate to the task.

From the viewpoint of the Single State Agency, the reason why they are for the most part Single State Agency States is low population density and large geographic areas. In setting the authorization levels, and then in the funding, it was recognized that there was some irreducible minimum. Unfortunately, that irreducible minimum is not sufficient to perform the task assigned. In some cases, there are sufficient funds available between the SHPDA (State Agency) and its single HSA, to do the job, but there is a lack of flexibility in distributing the funds. In our case, the State Agency has funds which it cannot possibly use, whereas the HSA cannot hire the fifth professional staff member called for to qualify for full designation. The factor which causes this situation in the sparsely populated and rural HSAs, whether single or multiple, is distance and the resultant travel cost. The money, which would normally go for staff people, is consumed in travel expenses for Board, Executive Committee, Subcommittees and staff.

Being well aware that authorization levels do not equate with cash in the bank, the Bill being considered by this Subcommittee in Section 206 through 208 does recognize the financial plight of the small agencies and the difficulties encountered in implementing the Act in sparsely populated regions.

I appreciate the Chairman and the Subcommittee letting me make this presentation on behalf of the people who are trying to make the Act work in those states which have a single health systems agency.

Mr. WALGREN. Thank you.

Any further comments?

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman. I am particularly impressed by the character and quality of the presentations and feel that you are vitally interested—no question about it. I notice Wyoming has one HSA for every 100,000 people. Do you want to keep it that way?

Mr. NEIBAUR. I don't particularly want to be in opposition to my Governor, but I wish you would have ask me that before he came and talked. He would not like to see it two HSA's either. I think he expressed that. He has been pushing the 1536 adoption. We are a rather large State, and if you really took a hard look at it, went back to the intent of the law, we shouldn't be an HSA at all. We don't represent that whole health system that is incorporated in the law.

Mr. CARTER. I believe that you do, and even though you have 400,000, I believe that your areas could be broken up into smaller segments. I wrote that with this in mind—you could have smaller HSA's, the contour that was accepted, and that is part of it. Of course, one has to take that to HEW and prove his case, but it can be done, and a prime example is the Eastern Shore of Maryland, which had 260,000 people. Is that not correct? 55,000 we usually think of, and most States have more than that.

I was interested in how you become an HSA there on the Eastern Shore of Maryland because of your geographic position. The Chesapeake Bay sort of cuts you off. Is that right?

Mr. DIERKS. I would say that was the prime consideration, the Chesapeake Bay.

Mr. CARTER. How is your HSA working?

Mr. DIERKS. I think it is working very well. We have nine subarea councils. They are all active, take considerable staff support. We are committed to health care and planning.

Mr. CARTER. You have \$346,000?

Mr. DIERKS. In the 8 years we have been organized, we have raised that.

Mr. CARTER. We compliment you on that. It requires an effort on the local level which we rarely see any more.

Mr. DIERKS. I think we have been very fortunate.

Mr. CARTER. The gentleman from Wyoming would not spell out how States should conduct internal authority. Is that correct?

Mr. NEIBAUR. The problem we have, and I tried to address it there—there is such a diversity in the way the governments are structured. There are a few basic things that are common to all of the 50 States, but there are an awful lot of internal differences, and the certificate-of-need laws brought this out where it should be inserted in the administrative family, how it should operate, how the rules have to be promulgated in terms of the States own legislative and administrative rulemaking powers, and things like this.

Mr. CARTER. You don't have to sell me on that. I agree with you.

Mr. NEIBAUR. I think the committee is. I am trying to encourage the committee to use what influence it obviously has to keep thre Federal bureaucracy from trying to stuff us all into the same mold,



making us all march to the same drummer and make us all fit into the same mold.

Mr. CARTER. Do you think that you are inadequately funded, now? Is that correct?

Mr. MEYER. Yes.

Mr. CARTER. I believe you received \$275,000 for your HSA. Is that correct?

Mr. MEYER. No. We receive \$175,000. We are requesting \$275,000.

Mr. CARTER. 70 cents per capita?

Mr. MEYER. 70 cents per capita would not help our situation. We have a total of 215,000 population.

Mr. CARTER. 250,000 in your—

Mr. MEYER. Approximately 215,000 permanent residents and 48 million tourist visits.

Mr. CARTER. Are you divided into primary, secondary and tertiary care regions, or do you have a central region of tertiary care?

Mr. MEYER. Tertiary services in western Colorado do exist. The majority of tertiary services do go across the continental divide, or to the south to Albuquerque, or to Salt Lake City. We do have limited tertiary services in western Colorado. The biggest need we have is still in the primary care area. We have several communities without physicians. We have hospitals that operate with one or two physicians and they are beleaguered by the type of care they have available to render to their patients.

Mr. CARTER. I suppose in your area, in fact in all of the areas, you have many cases of when you need the attention immediately of a skilled physician, living in isolated areas such as you do. I am not particularly sold on this day of transportation—you can travel by air much faster than you can travel by car. According to emergency medical legislation, which we passed, you can get helicopter service. Do you use those in your area?

Mr. MEYER. Fred [Mr. Dierks] has a situation which allows him, I think, to utilize the State services available. I have been involved in emergency services previous to coming to the HSA, and which looked into the idea of setting up a service. It came down to not being cost effective. The area we covered was in excess of 20,000 square miles. The number of cases or calls that air ambulance would have to make to justify paying for itself, is just not there. Helicopters could be used and are used on periodic basis as emergencies arrive, courtesy of industry and others that donate them, but to operate and maintain or support helicopter is not, at this point in time, effective, or efficient.

Mr. CARTER. What would you expect of a primary care region? What types of treatment? You live in an isolated area and you know the things.

Mr. MEYER. I would be hard pressed, as a nonphysician, to respond directly. I think a physician in a rural area needs to be able to provide the care his patients need, and be supported by the kinds of services that secondary and tertiary centers can provide to them.

The biggest problem we see in our area is not having the support base. We have a few specialists in a few areas. They have an awful large clientele, and can't get out to help the primary care physician to meet the real crisis cases that come up.

Mr. CARTER. Sometimes we try to tell medical schools that we should teach certain subjects, basic training, certainly obstetrics and surgery and internal medicine, of course, is very, very important, as I see it. I feel that your basics, these subjects should be covered as well, a physician should be pretty well grounded in various disciplines. I think sometimes we are weak concerning the training by adding subjects that really don't perfect them too much.

Thank you. It has been a pleasure talking to you. I came from a rural area, too, and I know what it is.

Mr. WALGREN. Would you presently state why health coordinating approve the health State plan, and the Governors, especially in single State areas where there is a section 1, the same geographical area, one HSA in the State, the Government should approve the plans under those circumstances.

Do you feel the Government should play that role.

Mr. NEIBAUR. I think the amendments which give the Governor more involvement in the committees bill are very desperately needed, particularly as applies to the single State agency. One of the problems I see that we need is getting governmental involvement in health. If he has to read, understand, and approve that document that comes up, if he does his homework, he is going to find out what is going on in his State. I don't want to be in the position of putting down my own Governor.

Mr. CARTER. Can I just say this—I have come to the opinion, after studying this issue and watching it over a period of time, that we should have no independent Federal agencies rendering services within a State. Certainly, we should have safeguards against politics, but we see too many agencies without a head, and that is why some of our different agencies, Mr. Chairman, as I see it, are not effective, are wasting money.

Mr. NEIBAUR. Those elements that are in the bill that deal with enlarged role of the Governor, I think, are very helpful. I certainly urge their passage for that very reason, to get more interest in the development of State policy along these lines.

I recently responded to a letter from the other House, a member of that committee, and one of the questions was, how effective is the local political—the requirement of keeping the local, political people involved? And I had to respond we tried desperately. They are a bunch of busy people. In rural areas, you don't have full time paid county commissioners, full time paid mayors. They are part time. And to try to involve these people in another activity beyond their local responsibility as local elected officials is tough to do. Anything in the law to get more political involvement of these people in the process would be helpful. With the advent of this law, all of a sudden, the Governors and political people seem to be quite interested on the national levels, national groups. I have lost legislators who we originally had elected to our Board because they were too busy. I have lost a county commissioner for the same reason. We try to drag them in. We need it, because then they get involved in making some rational decisions.

Ms. HOSKIN. Could I answer that also. I think there needs to be a balance. The State definitely needs to be involved. I have no argu-



ment with that. However, if the HSA is to do its job, it needs to have a certain amount of autonomy and freedom to go ahead and implement the plans it has come up with itself.

In other words, for example, the section I spoke to goes on to have the Governor appoint the chairman of the SHCC. I can't see any reason why he should. If the SHCC is going to function, he appoints it and it should go ahead and do its job. He doesn't have time to mess with it. Let them come up with their own chairman, do their own thing. There has got to be a balance.

Mr. WALGREN. And then one other thought. Apparently, in an area such as yours, where essentially you have been underserved medically, a great deal of the effort goes into developing those services. I understand there has been a provision in the act for health services development, but that has never been funded by the administration, and you are essentially using the planning funds as development funds?

Ms. HOSKIN. Not exactly.

Mr. DIERKS. I think I would characterize it more, to use our council structure, as an example. We have some staff that work closely with our nine county committees, and I think it is those groups that have been very active in trying to produce more primary care services. I would say we clearly have not funded developmental processes by way of using our planning funds. Rather, we have technically assisted community groups, including our own subarea councils, to proceed along those lines.

I think that both the experience of western Colorado and our own agency have heavily utilized national health, rural health initiative programs.

Mr. WALGREN. Taking your base funding as you experienced it, how much money would you need to do an adequate job of development planning? In other words, from your experience, and receiving \$150,000?

Ms. HOSKIN. \$175,000.

Mr. WALGREN. How much money would you need from the administration if you were to do an adequate job in the area of health services development?

Mr. DIERKS. As I recall, I believe it was up to 50 cents per capita. Maybe the staff can correct me. I think we have given it up as a lost hope so long, we have forgotten about it. If memory serves me, I believe it was 50 cents per capita. For a region such as ours, that would be roughly \$130,000 per year, and I would see that as a first year, probably more than we could utilize effectively, but I think, very rapidly, we could begin to utilize funds at that level for the development of additional resources.

Ms. HOSKIN. As I understand it, the area development funds were to be used by other people and we were going to give them, for example, to a school district to implement a school health program. Now, we can plan for this type of thing with our planning moneys, but we don't have any moneys to actually implement programs.

Mr. MEYER. In response to your direct question, with the additional funding necessary, we have looked at one thing I think is unique. We have the oil shale industry which is going to blossom on the scene. We

cannot deal with it at this level of funding we now have, so to answer your question, I would probably like to have an additional staff person I could dedicate to this type of thing. We are looking at \$20,000 to \$30,000 for that particular effort.

Mr. WALGREN. Was there something you wanted to add? I am in very much of a time crunch.

Mr. PARR. This is what we would use most of the money for, is to attract doctors to come into the area.

Mr. WALGREN. We have to recess briefly for 10 minutes.

If there is anything further, further thoughts you would like to add when we come back, we can do that.

[Brief recess.]

Mr. ROGERS. Our next witness will be Mr. Gifford Johnson, president of the National Association of Single State Agencies, Cheyenne, Wyo., and Mr. Budd Norris, who is the president of the Homemakers Division of the Upjohn Company, Kalamazoo, Mich.

We welcome you gentlemen to the committee.

If you will take your places at the witness stand, we will proceed. We are pleased to have you.

Your statements will be made a part of the record, and you may proceed.

If you would like to summarize your statements and make major points, this would be helpful.

#### STATEMENT OF BUDD J. NORRIS, PRESIDENT, HOMEMAKERS UPJOHN

Mr. NORRIS. Mr. Chairman, Mr. Carter, I am Budd Norris, president of Homemakers Upjohn, the largest home care provider in the Nation.

My statement is brief, and I believe, to the point.

As you know, home health care expenditures represent a scant 1 percent of combined medicare and medicaid program funds. While it is clear that chronic diseases, not communicable disease, is now the major cause of death, home health care, which chiefly treats chronic disease, is at the bottom of a long list of health priorities in the United States.

Report after report tells you and us that there is an urgent need for expansion of home health care programs to serve particularly the elderly and chronically ill. The need is growing in direct proportion to the growth of the elderly population from 10 percent today to 17 percent of the total population by shortly after the turn of the century.

Existing home health agencies, according to Federal estimates, are serving only 10 percent of the population in need.

If this committee imposes certification-of-need requirements on home health care as specified in H.R. 10460, the expansion of home health care to meet this enormous need will be effectively scuttled.

Certificate of need is aimed at controlling costs by preventing duplication of health services and facilities. Certificate of need is also a very effective method of locking out competition, denying innovation, discouraging resource development. According to a recent study, cer-

tificate of need favors institutionally based providers, thereby encouraging maintenance of the status quo. The status quo in this case is represented by the boards of health systems agencies, heavily weighted toward the existing institutionally biased health delivery system.

Here is how we see the reality of the situation. Proponents of home health care inclusion under certificate-of-need requirements are those who wish to keep tax-paying agencies out of the program, either for fear of competition or because they believe that the health marketplace should not be profit oriented, even though proprietary organizations may be less expensive than voluntaries. Profit, or loss, is in the health arena, has always been in the health arena, as it has always been in America. If an agency is providing quality services at reasonable costs, why is it afraid of competition? Especially when, in almost all areas of the country, the home health care industry needs every qualified provider it can get.

In the past, certificate of need has not guaranteed quality or controlled costs. Licensing of personnel and agencies will. Uniform standards for provider certification will. Utilization review will. Program monitoring will. Your committee took important action, perhaps a commitment, when it included section 18 in Public Law 95-142 to study and develop standards for home care. This process has already begun at HEW and is scheduled for reporting back to Congress by October 1978. Mr. Chairman, under that law, your committee has ordered HEW to study the need for home health care inclusion under Federal certificate-of-need requirements. H.R. 10460 preempts your own mandate.

This committee's legislation would do better to order that State and local health planning include provision of home health care as a priority. The health planning process involved in implementing that priority would hopefully develop a formula for determining the need for home health services. Neither HEW nor Congress has a sound formula. We do know that as much as 90 percent of the current need is unmet. We suggest a moratorium on certificate-of-need for home health agencies until there is information available to make qualified planning decisions.

To quote a Hunter College study of these issues, "Certificate of need should not even be considered until home health care is incorporated into national health planning goals and integrated into State and regional health plans. Such planning must precede certificate-of-need regulation and should not be confused with it." We are submitting this study to your committee and hope that it will be included in the record.

Thank you, Mr. Chairman.

[Testimony resumes on p. 1182.]

[The study referred to follows.]



## HOME HEALTH CARE REGULATION: ISSUES AND OPPORTUNITIES

by Louis R. Gary, Herbert Harvey Hyman, Ph.D., Allen D. Spiegel, Ph.D.

### SUMMARY

Home health care has historically received a very low priority in the United States. In other developed countries it is a large, integral part of their health care delivery system. Although home health care does not have a strong legislative focus yet, substantial data are helping to build a broad consensus that the vast, unmet need, particularly of the elderly and chronically ill, can best be served by expansion of home health care. In addition, the special needs of children and adults are also receiving attention. There is evidence that chronic diseases have replaced communicable diseases as the major cause of death. The projected growth of the elderly population means that future needs will be even greater. It will not be possible to fulfill these needs in a cost effective way if the institutional bias of delivering services through hospitals and nursing homes continues.

Recent federal legislation has established Certificate of Need (CON) as the process by which health care providers must receive state approval before building or renovating a facility, or adding a new service. Although CON was expected to limit costs, it has not done so. Certainly, strict regulation of cost and quality of home health care is needed, but CON is an ineffective way to organize the delivery of services and limit costs. Furthermore, as a process, CON is biased in favor of

institutionally-based providers and maintenance of the status quo. Vested interests have a history of trying to use earlier state CON regulations to control their turf, limit competition, and consequently stifle innovation. CON SHOULD NOT EVEN BE CONSIDERED UNTIL HOME HEALTH CARE IS INCORPORATED INTO NATIONAL HEALTH PLANNING GOALS AND INTEGRATED INTO STATE AND REGIONAL HEALTH PLANS. Such planning must precede CON regulation and should not be confused with it.

There are alternatives to CON which can achieve quality service and moderate costs, including licensing of personnel, standards for provider accreditation, and utilization review. Planning for these alternatives should begin now. Strict enforcement and national guidelines are essential. Without such an approach, the expansion of home health care will be fragmented at a time when the evidence suggests a comprehensive use of home health care is a cost effective alternative for many levels of care given in hospitals and nursing homes.

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### RECOMMENDATIONS

The authors believe that the following seven recommendations deserve priority attention.

#### INCLUDE HOME HEALTH CARE IN NATIONAL HEALTH PRIORITIES

Home health must be included in the priorities being developed by the National Council on Health Planning and Development. Home health agencies should work together to document their position and to present this material for consideration. Health System Plans on a local level should reflect this national priority.

#### MORATORIUM ON CERTIFICATE OF NEED

There should be a moratorium on the further expansion and inclusion of home health in state certificate-of-need programs.

#### APPLY LICENSURE REGULATIONS

Using standards agreed to by the national organizations involved in home health, states should be encouraged to license agencies and personnel to perform specific functions and tasks.

#### EQUITY IN CERTIFICATION

Any home health agency meeting the requirements for certification should be granted certification regardless of funding auspices. There should be equity for all applicants for certification. Periodic recertification of all home health care agencies should be required.

#### PROMOTE ACCREDITATION AND ENFORCEMENT

A joint committee of representatives from the national organizations involved in home health should develop approved standards, norms and criteria to use in a national accreditation program. Further, this committee should propose enforcement mechanisms in cooperation with government payees, insurers and professional societies, consumers and other associations to legally assure quality care without abuse or exploitation.

**COST EFFECTIVENESS**

National standards for uniform cost reporting of units of home health service should be developed. This would permit better determination of cost effectiveness of home health and comparison of services and agencies.

**INCREASED ACCESS**

Medicare's three day prior hospitalization requirement for home health eligibility should be removed. The skilled nursing requirements should be modified to permit other forms of care. Limits on the number of home health visits should be based on medical necessity.

## HOME HEALTH CARE REGULATION: ISSUES AND OPPORTUNITIES

Many attempts have been made to contain rapidly escalating costs while assuring an adequate quantity and quality of service. Among these attempts are neighborhood health clinics, prepaid health maintenance organizations, prospective reimbursement, utilization review, and physicians' assistants. Despite these efforts, there was a 20% increase in health costs in 1976, reaching a new high of \$140 billion.

The method that has received wide attention as a possible overall strategy is the certificate of need (CON). Under CON regulations, a health care provider must obtain state approval before a new facility or service can be added. CON has been used largely to make determinations about the largest part of health costs, the supply of hospital and nursing home beds. Many interested parties have called for the application of CON regulations to home health care. The call is being made at the very time that the expansion of home health care is being advocated as a cost saving alternative to institutional care. Not only are institutional providers, hospitals and nursing homes calling for CON regulation of home health care, but so are established, voluntary, not-for-profit home health services.

After reaching a plateau of growth in the first few years after the enactment of medicare and medicaid, there is now a new recognition of the value of home health care and an increase in the number of personnel and new agencies. Some health care professionals are afraid that this rapid increase will bring confusion. Established home health agencies are concerned about uncontrolled growth. They fear its possible harm to the public and to their own reputations. Nevertheless, the federal Certificate of Need regulations issued January 31, 1977, do not include home health care as a service subject to CON review. Individual states may include it in their CON legislation if they wish.

Within this setting, the examination of home health care will cover:

- Special needs of the elderly and other population groups and the future of home health.
- Certificate of Need as a strategy for containing costs and better organizing the health care system.
- Fragmentation and competition among the vested interests for patients and control of home health care.
- Manpower specialization and the need for coordination and continuity of care by licensing and accreditation of personnel and agencies.
- Quality controls and enforcement.
- Cost containment and cost effectiveness.
- Recommendations needed for home health care as an integral part of the health care delivery system.

This examination will support the conclusion that regulation of home health care is absolutely necessary, but Certificate of Need is *not* an effective way to control costs or organize the delivery of home health care.

### HISTORICAL OVERVIEW

The home has always been the primary institution for care of the sick. Such care was rendered by family and friends. Reliance on institutional care in hospitals and nursing homes is a 20th century phenomenon as is the professionalization of home health care. During the 15th century, in Ghent, Belgium,

the mentally ill were cared for in foster homes. In the United States, the first organized home care programs was established by the Boston Dispensary in 1796. During the second half of the 19th century, visiting nurse associations began to develop home care programs. It wasn't until after World War II that the first hospital-based home care program was established at Montefiore hospital in New York City. In 1966, medicare recognized a broader range of services by introducing the term "home health aide."

At the present time, medicare, medicaid, health maintenance organizations (HMOs), neighborhood health centers, older American legislation and social services provisions of the Social Security Act all reflect the growing recognition of the value of home health care services. Abdellah notes that home health was a \$1 billion dollar industry by 1976. Four national organizations have now joined in a definition of home health that shows its wide scope. The National League for Nursing has stated:

*The term 'home health care' designates that component of comprehensive health care wherein services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and/or disability. Services appropriate to the needs of the individual patient or family are planned, coordinated, and made available by an agency/institution (or a unit thereof) that is organized for the delivery of health care through the use of employed staff, contractual agreements, or a combination of administrative patterns.*

*Home health services are provided under a plan that includes, but is not limited to, such appropriate services components as medical care, dental care, nursing care, physical therapy, speech pathology service, occupational therapy, social work, nutrition, homemaker-home health aide services, transportation, laboratory services, and the provision of medical equipment and supplies.*

Conditions of payment for home health agencies under medicare requires nursing care plus one other specified service. However, Ryder<sup>75</sup> believes the intent of the law was to provide more comprehensive services. More than 2,000 medicare certified home health agencies were surveyed and 54% were at minimum certification level, 27% had two additional services, and only 4% had five additional services. A 1973 Massachusetts home health survey, reported by Morris and Harris<sup>72</sup>, showed that 47 agencies said they offered homemaker-home health aide service. In fact, only 14 agencies did so, and that was largely through subcontracting.

Currently, the situation is detailed in Lawson's<sup>73</sup> comments about the teaching of chronic illness and aging to medical students and other health professionals. Long term care was inadequate as he noted for the following reasons:

- There was a poor discharge planning by health care institutions.
- Prescribed drug and dietary regimens were incompatible with real life situations.
- There was muddled involvement of professional agencies.
- There was an uncomfortable inference of an absent or remote "leader of the team," the physician.

Addressing the last item mentioned by Lawson, the Massachusetts Department of Public Health<sup>46</sup> reported that the most infrequent problem encountered was the failure to

secure physician supervision (only 2% of the survey group). On the other hand, the most frequently encountered problem was that families did not have the commitment or capacity to support relatives in the home (12% of the survey group).

Trager<sup>89</sup> summed up the situation by noting that home care provided for the restoration of normal rights and privileges to persons who happen to be ill.

### PRESENT AND POTENTIAL HOME HEALTH CARE NEEDS

In considering the needs of the elderly, it is clear that the data solidly support the need for increased home health care. The overwhelming consensus of the 1976 Regional Public Hearings<sup>96</sup> on home health care was that many elderly persons were unnecessarily institutionalized. A study of all nursing home residents in Massachusetts by Morris and Harris<sup>92</sup> showed that 14% needed *no* institutional care for medical reasons and about 26% needed *little or no* medical care as a reason for institutionalization. Lawson<sup>99</sup> also asserts that home health care "is an essential economic and humane component in systematic care of the elderly."

People are living longer and are being afflicted with debilitating, chronic diseases. In 1900 the three leading causes of death in the United States were influenza and pneumonia, tuberculosis and gastritis. Today the leading causes of death are heart disease, cancer and stroke. Influenza is the only communicable disease among the 10 leading causes of death. Two out of every five elderly persons have a minor or major degree of disability and about half of the severely disabled who are elderly have had the disability for five years or more. Furthermore, as Brickner<sup>7</sup> found, the aged may be home-bound and unable to enter the health care system without assistance. The multiple problems of the elderly may make it difficult for them to get appropriate care.

For long term illnesses such as arthritis, heart conditions, hypertensive diseases and diabetes, the percentage of individuals 65 and over who are disabled by these conditions is almost double in each case compared to the 45-64 age group. The aged population is growing rapidly. Today, there are about 21 million persons over 65 years of age; by 1985 there may be 27 million; and by the year 2,000 there may be close to 31 million elderly—perhaps 17% of the population. There will be more older people with more disabilities needing more health care, more physician visits, more hospital stays, and more personal care.

While it is true that most of the home health care services are needed by the elderly, there is also a home health care need for younger people. A study by the Massachusetts Department of Public Health<sup>46</sup> of 3,691 patients served by home health agencies in 1974 showed 77% of the patients were 60+ years of age, and that 4% were under the age of 20. However, a National Health Interview Survey found that 73,000 noninstitutionalized children under 17 years of age had trouble getting around. That survey excluded those with chronic illnesses and impairments. Special aids were needed by another 39,000 in order for them to get around. Assistance from another person was needed by 44,000 more young people, while 37,000 were confined to the home.

Home health care is appropriate from the beginning to the end of life. Yanover<sup>108</sup> compared traditional institutional care and home care for infants and mothers. Patients were discharged as early as 12 hours after delivery with home care follow-up. There were no significant differences in trends or

types of morbidity during the 6-week period after delivery. The home health care given was safe, economically feasible and well accepted by patients. A newspaper<sup>87</sup> recently reported that a New Jersey hospital became the first in the state to offer a 24-hour program of home health care to cope with the special needs of terminally ill cancer patients and their families.

Even in situations where most people would think that institutional care would be an absolute necessity, home care is being tested. Mather<sup>47</sup> reported on home and hospital care for myocardial infarctions (heart attacks). There was no statistical difference in the mortality rate after 330 days. In fact, the home care group had a mortality rate of 20% compared to the hospital group's 27%. Home care was judged to be a proper form of treatment for many patients, particularly for those over the age of 60 and for those with an uncomplicated attack who were seen first by their family doctors. Haber<sup>28</sup> reported similar findings on hospital based home care after a heart attack.

A sampling of the literature of recent years reveals the types of patients and conditions receiving home health care: paraplegics<sup>4</sup>, spinal cord injuries<sup>91</sup>, autistic children<sup>31</sup>, hemophiliacs<sup>49</sup>, strokes<sup>4</sup>, small bowel resections<sup>38</sup>, dialysis patients<sup>71</sup>, patients who require oxygen therapy<sup>90</sup>, handicapped children<sup>81</sup>, dental patients<sup>29</sup>, retarded children<sup>18</sup>, vascular surgery patients<sup>74</sup>, respiratory illnesses<sup>24</sup>, mental illnesses<sup>72</sup>, terminal illnesses<sup>107</sup>, young chronically sick<sup>44</sup>, cancer patients<sup>35</sup>, patients requiring medication<sup>85</sup>, and general early discharges<sup>84</sup>.

In urging more health care at home, Burch<sup>9</sup> Said, "... the public has the impression that good medical care is only possible in a hospital and that complex diagnostic procedures and measurements and therapeutic measures are always necessary for excellent medical care."

Since statistical data as well as a review of the literature demonstrate that home health care is not confined to the elderly, it is obvious that the expansion of home health services as part of the treatment plan can be applied to a wide range and level of care.

### HOME HEALTH NEEDS

The United States has one homemaker for every 5,000 people. By comparison, Sweden has one for every 121 persons, and the United Kingdom has one for every 726 persons<sup>34</sup>. The National Council for Homemaker-Home Health Aide Services<sup>37</sup> projects the need for these services at 300,000 persons, one for every 1,000 Americans under the age of 65 and one for every 100 persons over 65. There will be a problem of qualified manpower if those projections become a national goal. A survey of home health care services received under medicare in 1974 reveals that all 2,222 home health agencies rendered nursing services, 72% delivered physical therapy services, and 67% had home health aide services. In 1974, 57% were government agencies, 24% were visiting nurse organizations, 10% were hospital based, 6% were other agencies including proprietary, and 2% were combined government and voluntary agencies.

The policy problem is how growth should take place. How many agencies are needed? What is the minimum size of an agency, and what services should an agency provide? Should present agencies be encouraged to grow while new operations are kept out? The answers to these questions will shape the type and quality of service available in the decades ahead. We have no national guidelines and little national planning to en-



able the federal, state and regional levels to answer these questions.

On a federal level, Abdellah<sup>1</sup> notes that the Health Services Administration is distributing \$3 million in demonstration grants for expansion and initiation of home health care services for the 600 countries of the country presently without services.

Somers and Bryant<sup>79</sup> discussed the need for home care, its neglect, and the advantages to be expected from its use:

- An option for care of the elderly infirm, disabled, and handicapped to receive services while remaining at home.
- Needed assistance to overworked professionals who can supervise care at home with fewer visits to the home.
- Employment for mature persons without much formal education or work experience.
- An opportunity for substantial savings in the fight against inflation.

Target<sup>89</sup> also specifies the benefits of home care upon cost and quality:

- Increased range of options for the provider, the community and the individual.
- A selection and combination of services to meet specific needs that is capable of prompt adjustment and of change in kind, intensity and duration of services.
- Services are focused on an individual in need of care

rather than on groups and allows for economy in the use of professional and other staff.

- Makes therapeutic use of the personal environment.
- Well trained paraprofessionals are extensively used.

After 15 years of the study of long-term care and the testimony of hundreds of health consumers and providers, in 1974 the U.S. Senate Sub-committee on Long Term Care<sup>103</sup> concluded:

*If home health care services are readily available prior to placement in a nursing home, there is convincing evidence to conclude that such care may not only postpone but possibly prevent more costly institutionalization. What is particularly appealing from the standpoint of the elderly is that home health services can enable them to live independently in their own homes, where most of them would prefer to be.*

Somers and Bryant<sup>79</sup> also echo this comment when they say, "Nevertheless, the broad conclusion is inescapable: home health care, when efficiently organized with good backup services, is a highly cost-effective way of caring for the elderly."

Obviously, the federal priorities for cost control and the surveillance of the quality of care embodied in the National Health Planning and Resources Development Act (P.L. 93-641) and Professional Standards Review Organizations (PSRO) are potential vehicles for providing encouragement and supervision of home health care expansion. Right now, their potential is untapped.

## CERTIFICATE OF NEED AND HOME HEALTH CARE

### CON: WHAT IS IT?

As of 1976, some 35 states had enacted CON laws, 16 of them mandate coverage of home health care. This is optional since federal guidelines do not mandate its coverage. P.L. 93-641 requires all states to establish a CON program before October, 1980. These programs must have the authority to approve or disapprove "new institutional health services proposed to be offered or developed within the State." Section 1523 of P.L. 93-641<sup>93</sup> states:

*Such programs shall provide for review and determination of need prior to the time such services, facilities and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State.*

To carry out these reviews, P.L. 93-641 divided the country into about 200 health service areas, each with a Health Systems Agency (HSA). Within each service area, the HSA must prepare a Health Systems Plan (HSP), a 5 year long range plan for the region, and an Annual Implementation Plan (AIP), a short range plan. The HSP states the HSA goal and objectives and the AIP describes how the HSA intends to work toward the implementation of those goals in the next year.

The HSA reviews CON applications in light of the goals and priorities of its HSP and AIP. Applications related to the HSP's priorities may receive the HSA's recommendation for approval provided other requirements are met. Recommenda-

tions of the HSA are submitted to the State Health Planning and Development Agencies (SAs) created by P.L. 93-641. SAs have final authority in approving or disapproving all CON applications.

To provide a national framework, Congress identified ten priorities in P.L. 93-641 in the formulation of national health planning goals to guide SAs and HSAs. Among these priorities, those that have direct or indirect reference to the home health care are:

- Provision of a plan of primary care for underserved populations.
- Increased use of physicians' assistants.
- Provision of varying levels of care on a geographically integrated basis.
- Concern for quality control and uniform cost accounting.

A National Council on Health Planning and Development will be giving close attention to these goals and others relating to the health needs of the nation. However, the informal interpretation given by government officials to guidelines issued by the federal Bureau of Health Planning and Resources Development was that the HSAs concentrate on acute and long term institutional care in their first HSPs and AIPs.

The failure of P.L. 93-641 to mention the explicit needs of home health care together with the exclusion from coverage by the newly issued federal regulations will further discourage HSAs from emphasizing home health care in their plans. Rationales for home health care's exclusion from the regula-



tions include the fact that such care represents only 1% of the total expenditures for health. However, there is no indication that federal authorities have a desire to prematurely restrict the growth of home health care, even if they have not adopted a policy to encourage its expansion. Still another reason for exclusion is that many of the home health care services and facilities are so small that several would not be eligible for review under the minimal federal Certificate of Need criteria. These criteria require CON review of applications if one of the following four elements is present:

- A new facility or organization is constructed or formed to provide home health care services.
- A capital expenditure in excess of \$150,000 is required.
- There is a specified increase in the bed capacity of the health facility.
- The addition of new health services, except home health services, which were not offered in the preceding 12 months is subject to review.

These minimum federal criteria can be made more stringent by states, which has happened in a number of northeastern states. Such misuse of CON by states is at odds with the implicit federal policy not to use CON to prematurely restrict the growth of home health care. Established home health care leaders expressed a strong interest in CON programs because CON aims to:

- Control and limit the rising costs of medical care.
- Prevent duplication in the use of costly technological equipment and other services.
- Reduce waste of scarce resources, including personnel.
- Rationalize the use of existing and proposed medical services in the region.
- Stabilize resources by balancing them against the established need of the region.
- Handle competition among providers in a fair and equitable manner.

However, policy-makers and professional planners examining the state of affairs in home health care could easily come to the conclusion that the CON program might be a major strategy for regulating the potential for turmoil in the field. Established and respected voluntary non-profit and public home health care agencies witnessing the onrush of new competing entries into their domain, particularly the proprietary and new not-for-profit agencies and the "independent" freelancing aides, envision an erosion of their reputations and see the newcomers as having lower standards. Some urban and suburban areas and overpopulated with home health care services while the rural and inner cities have a dearth of such services. Some agencies are under the scrutiny of tough licensing, accrediting, supervision and standards while others do as they please. Naturally, CON regulation is seen as a positive way to bring some order out of this impending chaos before the field is saturated. One must investigate whether reality conforms to the stated intentions of the CON program.

### CON IS A MIXED BLESSING

In a recent book on health regulation and certificate of need, Hyman<sup>33</sup> identifies inefficiency and conservatism as two

important shortcomings in the implementation of CON laws, particularly in their impact on cost containment on hospital expansion.

**CON REINFORCES INEFFICIENCY:** By regulating only new services and facilities, old, inefficient and high cost facilities may be retained. A new facility or service is measured for need against all existing services. Even if the new service can offer higher quality care at lower cost, the new service will be disapproved if the state regulating agency determines that the need is already being met. Home health care has a proliferation of small, specialized agencies: some are licensed and accredited, and others are not. A CON program will do nothing to organize or improve these services. CON can only require that the new agency show how services will be provided to a needy population in an efficient and effective manner. Only on that basis is the applicant supposed to be approved after meeting some other basic criteria. However, approval of a CON proposal does not really seem to depend on whether a need exists for the service. A recent national study<sup>42</sup> revealed that almost half of the jurisdictions surveyed approved 90% of the CON proposals even though regional plans for the area showed there was no need for the facility or service.

**CON FAVORS CONSERVATISM:** It is no coincidence that major national associations, such as the American Hospital Association, have been the chief supporters of CON programs. Between 1964 and the passing of P.L. 93-641 in January 1975, about 26 states passed CON laws. In this interim period, prior to P.L. 93-641, the state decision-making bodies were composed of a majority of health care providers and tended to make decisions in closed or executive sessions.

On the surface, P.L. 93-641 has made the decision-making process more open and democratic. HSA's governing bodies and review committees must have a majority of consumers<sup>39</sup>. Nevertheless, the major influence among the various interest groups involved in the review process continues to be the providers<sup>33</sup>. Providers see regulation, through CON, as a way of maintaining the status quo. CON guarantees their existence, even if they are inefficient. CON gives them an opportunity to legally restrict new entrants or innovations<sup>27, 42, 45</sup>. Furthermore, among the public, proprietary, and voluntary non-profit sectors in health, the non-profit sector tends to be the most influential partner, mainly because of its public interest image and because it provides most of the nation's basic hospital services. As a result, the proprietary providers with considerably less influence on the CON committees have not fared as well.

A study by Lewin Associates<sup>42</sup> showed that 16% of all "for-profit" proposals were rejected compared to only 3% of the "non-profit" and 4% of the "public" CON requests. Similarly, there does seem to be a movement to "freeze out" the proprietary home health care agencies from inclusion in any CON program that is passed. Recent federal regional public hearings<sup>46</sup> showed that, in answer to the question, "Should proprietary agencies participate in federal programs?" over 50% of those responding said, "No." Additionally, 80% of the representatives from the voluntary non-profit sector were in opposition. Significantly, when it came to the question of inclusion of home health care in CON programs, 100% of the voluntary, public, and governmental leaders favored inclusion, while a little over 50% of the proprietaries favored it.

Unfortunately, a battle between the profit and non-profit sectors is possible. A CON review body is not likely to approve a home health care application—even if there is a demonstrated need—when the home health care forces argue publicly over whether a project should be accepted or rejected because of its auspices.

### IS CON PREMATURE?

There is no agreement among home health care leaders on a definition of home health care goals, accreditation and fund allocation, even though there are encouraging signs in that direction. Until there is more unity, it will be difficult for home health care to compete effectively for a larger share of federal and state health budgets.

### HIGH PRIORITY GOALS OF HSPs

It is a misconception to equate regulation with planning. Planning is essentially a normative, technical, dynamic and cyclical process that involves molding fact, theory, and policies in order to politically influence or bring about a course of action. Regulation is based on legal, routinized, rigid, administrative standards that result in decisions to meet current needs.

Regulation is viewed by federal officials as a means of implementing the goals and priorities of HSPs and AIPs. This requires that the HSP/AIPs should be developed first so the HSA review committees can measure CON as well as all other applications. Federal regulations recognize this difference by specifically stating that CON project reviews are not a required function of HSAs and SAs until their HSPs, AIPs and state plans are publicly approved<sup>79</sup>.

Home health care is not even mentioned once in P.L. 93-641. However, while home health care services are given attention in the goals being considered by the National Council on Health Planning and Development, this does not assure that HSAs will give much emphasis to home health care in their first year plans. On the contrary, home health care will probably be given a low status—if any status at all—because the informal interpretation of the federal guidelines places top priority on acute and long-term institutional care.

### HOME HEALTH CARE NEED MUST BE PROVED

Home health care agencies, like all other applicants, must prove that a need exists for their proposed services. A CON program is based on the premise that a balance exists between the real needs of specified segments of the population and the availability, affordability, and accessibility of services. Need is usually based on statistical data, which are abundant for institutional services.

However, there is only sketchy and unreliable data for home health care in much the same way as there is for the 80% of the nation's ambulatory care delivered in physicians' offices. An interesting evaluation of the difficulties involved in determining the need for home health care has been made by Trager<sup>80</sup>. Whether data is collected based on community surveys, on home health care agency records, on the availability

of funding, or on the estimates of experts, any number of biases are built into the unsystematically gathered data, limiting their reliability and validity. Under such circumstances, the review committee must fall back upon its own judgments and prejudices as well as its high priority HSP goals to determine whether or not it should approve or disapprove a home health care project.

### FINANCIAL VIABILITY AND SERVICE COORDINATION REQUIRED

Even if the review committee were predisposed to approve such a project, the issues of sufficient funds, to run the program and the necessary cooperative formal agreements with other agencies in the health system would still have to be resolved. In addition, the review committee might well have a bias toward a particular model for delivering services. If the CON proposal were not consistent with bias, it would stand little chance of being approved.

As of 1976, 16 states passed CON legislation which required the review of home health care proposals. About 17 states, including some with CON laws covering home health care, require licensure of individuals or agencies engaged in home health care. However, the majority of states are totally unregulated with respect to home health care, except for the federal regulation of medicare requiring agency certification for reimbursement in home health care activities. Given this diversity in state and federal regulations, home health care has an opportunity to resolve some of its own problems.

At the same time, the experiences of those states with CON programs could be evaluated. As the federal regulations state, the Secretary of HEW is sensitive to the concerns of the home health care proponents of CON and plans to monitor the growth and impact of home health care on the health care system<sup>81</sup>.

### CON AND THE LACK OF CRITERIA

Besides these problems, there are difficulties in the interpretation of the criteria to be used for review and approval or disapproval of projects subject to CON regulations. Section 1532 (c) of P.L. 93-641 mandates nine criteria. These criteria are vague and imprecise. To illustrate the potential problems the criteria might present, four will be discussed briefly. Section 1532 (c) states that "criteria required . . . for HSA and SA review shall include consideration of at least the following:"<sup>82</sup>

- The relationship of services reviewed to the long-range development plan of the provider.
- The need that the population served or to be served has for such services.
- The availability of less costly, or more effective alternatives.
- The availability of resources including health manpower, management personnel, and funds for capital and operating needs.

These criteria represent minimal federal requirements. Many states will go beyond these by adding other criteria or

defining the criteria more precisely. Each will be discussed in turn.

**Criterion:** "The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services."

An HSA review committee examines the home health CON application against two plans. The first plan is the long-range plan of the home health agency applicant. The CON proposal must be consistent with the phased development of its own long-range plan. The second plan is the HSP developed by the HSA itself. In most instances, the CON application must relate to one or more of the high priority goals of the HSP. Unless the home health care agency's proposal is consistent with both its own plan and the priorities of the HSA's plan, the chances of approval are slim.

In those states where long-range plans are required for health facilities, as in New York, Massachusetts and New Jersey, this poses a special problem for home health agencies which are small. These agencies have neither the competence, financial capability, nor manpower to develop such a long-range plan. Even larger agencies may lack the planning expertise to develop such plans. In addition to expertise, the home health agency applicant must show knowledge of the goals and priorities noted in the HSP to insure that the applicant's long-range plan fits in with the region's needs. An HSP would tell the home health agency such things as the population needing services, the location of those populations and the type of agency that should provide such services. Without this knowledge of the HSP, the home health agency may find its own plan and CON application in conflict with that of the HSA.

**Criterion:** "The need that the population served or to be served by such services has for such services."

Definition of need is a difficult, complex, and sometimes unrewarding task. A burden is placed on the home health care applicant to specify the need of the population group it plans to serve. This target population should be similar to one of the high priority groups identified in the HSP. To collect the data required to show how a particular project will serve this population is usually expensive and time consuming. In the end, the small home health agency with marginal income will attempt to prove its case based on limited data, and possible place itself in a position of a contest between its interpretation of need and that of the review committee. Where an HSP places a low priority on home health care and the needs of the population served, the applicant is definitely in a disadvantageous position.

**Criterion:** "The availability of alternatives, less costly, or more effective methods of providing such services."

This criterion places the burden on the home health care applicant to show that its services are less costly or more effective than those already offered to the target population or those being proposed by other applicants.

Again, most home health care agencies may need outside help to perform acceptable cost-benefit analyses or to employ other management techniques which prove need. For example, the home health care agency may be asked by a review committee to show whether a homemaker supervised by a social worker is more effective than a licensed practical nurse or a registered nurse supervised by a physician. Applicants may have to show whether a specialized, single-service agency such

as one that offers only homemakers or home economists can provide a more effective and less costly service than a comprehensive, multiservice home health care agency. Again, the burden of proof is on the home health care applicant.

**Criterion:** "... the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services..."

Essentially, this criterion puts the onus on the home health care agency to prove it can deliver the services it promises to the target population in the manner outlined in its proposal. At the same time, it requires the applicant to show how staff will be secured. The review committee will want assurance that the proposed staff represents an addition to health resources in the region, rather than a redistribution of existing resources brought about by pirating staff from other agencies in the region.

Equally important, the review committee is interested in the financial capability of the agency to withstand delay in payment, heavy start-up costs, or delinquency in payment by clients or third-party payers. The 1976 Regional Public Hearings<sup>96</sup> said that unfavorable interpretations by government intermediaries caused many small home health care agencies to have a limited capacity to withstand heavy losses. The review committee must be assured that the applicant has the financial resources to serve the population it has specified is in need.

## VESTED INTERESTS COMPETITION, INNOVATION, PLURALISM

"Naming the fox to guard the chicken coop" is a classic theme in the analysis of interest group dominance. Established groups seek to hold on to their turf and deny access to newcomers. Often, groups accuse newcomers of failings in the same terms that were used by those who wanted to regulate the established groups. At some point in group development, the established groups have made sure they were written into the process and have, therefore, captured the agency regulating them<sup>12, 15, 43, 70, 92</sup>.

In the P.L. 93-641 model of health interest-group bargaining, the definition of providers and consumers as mutually-exclusive groups does not insure that they have mutually incompatible interests to keep them honest, according to Vladeck<sup>106</sup> in his examination of HSAs. Providers and consumers do not form homogeneous or monolithic blocs. Consumers on an HSA Board represent many different constituencies—geographic, economic and ethnic. The same is true of providers. The HSAs do not have two major interest groups. Vladeck sees "no majorities in such a system, only a series of fragmented and largely autonomous minorities," with "very strong norms of reciprocity and log-rolling. I get mine if you get yours..."<sup>106</sup>

The HSA's composition shows a bias in favor of interests committed to institutional care mixed with scattered representation from well established voluntary home health interests such as Visiting Nurse Associations. When such institutional interests are given power under CON to regulate entry into home health care, the results become predictable. Just as hospitals and nursing homes view the expansion of established voluntary home health care agencies as a threat to



their control, the established voluntary home health care agencies in collaboration with the institutional providers and some consumers view the proprietary agencies as competing for clients. Such conservative policies hurt the expansion of home health care by keeping out new providers who would vie for the turf. One of the ways this is accomplished is by restricting the definition of need. At a meeting of the National Association of Home Health Agencies, Milton Gan<sup>56</sup> explained how:

*Some of the very forces which most directly influence the health care delivery structure have a fundamental conflict of interest with respect to encouraging the growth and expansion of home health services . . . As long as a hospital has empty beds that pose a threat to the economic capability of the hospital, the policymakers of that institution would be derelict in their duties if they encouraged the development of those alternative modes of delivery which could further exacerbate the economic threats to the institutions.*

The alliance between established not-for-profit voluntary home health agencies and other elements of HSAs to restrict new home health applicants often takes the form of seeking to keep out proprietary home health agencies. Proprietaries have been introducing management practices which pose a strong economic threat and serious competition to the established agencies. While these practices are not new in the corporate world, they are innovative in the field of home health care. Proprietaries sometimes offer services on a module basis, on a 24-hour basis, on a basis of providing lower cost personnel. By using corporate management practices and taking advantages of economies of scale, proprietaries have been able to reduce overhead costs.

On the other hand, established voluntary home health agencies attack proprietaries as interested in profit, not service. The accusation is made that in order for proprietaries to make a profit, they provide poor supervision, drop patients after their funds are exhausted and give little or no training to their staffs. The established not-for-profit agencies are to be commended for seeking to uphold high standards for themselves and others that would prevent such abuses.

Established not-for-profit agencies use the term, "private, not-for-profit" perjoratively to attack new usually smaller not-for-profits as actually representing a profit motive hidden under a tax exemption. On a case-by-case basis, there may be validity to such charges about proprietaries and new, not-for-profits but the generalization does not hold. In comes down to an attack on the newcomer. The Congressional Budget Office considers the charge and dismisses it with caution:

*While there is no evidence that proprietary agencies provide poorer quality services than voluntary agencies, some observers believe that these agencies would maintain a profitable operation by selecting the patients who are least sick and thus require fewer resources. Quality control would be quite important but quality of home care is more difficult to monitor than nursing home care because its delivery is as dispersed as the population receiving it.*

One way to achieve equitable treatment among new and established providers, not-for-profits and proprietaries would be subject all home health care providers to a rigorous periodic recertification, perhaps every 5 years.

Organizational cost effectiveness usually does not thrive in a monopoly situation. There are some situations in which

CON might be considered a way of containing costs in home health care. One would be if heavy and inflexible capital expenditures were required, as is often the case in hospitals. Then, limiting competition in an area might be desirable. Other situations might include the possibility of saturating the field, or if unmet needs could be easily satisfied by the modest expansion of present home health providers.

Unless vested interests are held in check, competition will be restricted, the benefits of pluralism will be limited to the older established groups, and innovation may well be squelched.

## ALTERNATIVE STRATEGIES TO CON

There are other ways than CON to resolve the organizational difficulties of cost containment, quality control and the delivery system. Certainly, the setting of standards and the licensing of personnel could help to achieve some order and solve some of the battles over turf. Establishing norms, standards and criteria for the control of the quality of care being delivered should provide home health care agencies with goals that can be met by all participants. Cost containment requires many approaches including rate setting, as P.L. 93-641 suggests as a priority. In addition, cost alternatives could experiment with coverage for new skills and certify those services for reimbursement. These alternatives offer opportunities to attempt innovative approaches to meet the needs of the public.

## DEVELOP AND LICENSE DIVERSIFIED HEALTH CARE PERSONNEL

Licensure is usually administered by state governments for an individual or organization to practice an occupation or activity. Eligibility requirements establish specific educational attainments and other experience to insure quality and legally protect the public from unlicensed, unqualified practitioners.

Supervision of the home health care team is the physician's responsibility, but others also supervise home health workers, such as nurses, social workers and therapists. Each professional group will have to identify the tasks falling within its jurisdiction and the manner in which the aides will work under their general supervision.

Questions of licensure and standards also have to be answered using the history of other health care workers. This has usually been a state function and will remain so. However, national standards have been adopted by the states; these guidelines are prepared by the professional organizations, or other peer groups.

The physician has moved from doing something *to* the patient to doing something *with* the patient. The division of labor within the health care industry has multiplied, with many levels of care being given by multiskilled personnel. In 1974, there were 66 nursing home employees for every 100 residents. New professional health workers now include physicians' assistants, nurses aides, and occupational therapy assistants. Nonprofessionals in home health jobs are being subdivided to cover household skills such as cleaning and cooking.

In the 1976 Regional Public Hearings<sup>56</sup> the consensus (415

to 0) was on the need to expand services and to have broader coverage of homemaker-home health aide services by all third-party payers. There was also broad agreement on including transportation, home delivered meals, nutrition services and 24-hour coordinated services. Witnesses testified that eligibility should be based on the patient's needs. These needs extend beyond the elderly, including children, the handicapped and the disabled. This broad range of needs will require an equally broad range of training.

Based on her research, Abdellah<sup>1</sup> believes home health care programs have demonstrated the ability to expand the capacity of a delivery system by providing needed care while conserving scarce and costly resources—both institutional and manpower. The National Council for Homemaker-Home Health Aide Services<sup>28</sup> also makes the point:

*Institutional care, which requires that employees be on duty around the clock, cannot easily be varied nor does it allow individuals to do as much for themselves as possible. In-home care, on the other hand, can be custom-fitted to the needs of the individual and the families served, while simultaneously making the most of their strengths. For example, the hours a week of care, the duration of care, and the tasks performed by the homemaker-home health aide can all be fitted to the need and can be changed to meet a changing situation.*

With the nation going through a period of high unemployment,

Although the tasks related to home health care have been grouped into different categories, a consideration of six types gives an overview of the range and scope of personnel and functions as well as an indication of the possibilities of constantly evolving tasks. None of the list are definitive, only representative.

Professional Functions:	Tasks and skills of the physician, dentist, nurse, social worker, podiatrist, speech therapist, physical therapist, occupational therapist, nutritionist, practical nurse, equipment and supplies.
Home Health Aide/ Homemaker Functions:	
• Health Care	Assist with occupational therapy, speech therapy and other therapeutic measures, exercises, medication giving, rubs, massages, hot packs, foot care.
• Personal Care:	Bathing, dressing, walking, transferring patients, toileting, feeding and shaving.
• Household Tasks:	Cleaning, cooking, laundry, shopping, sewing and mending.
• Leisure Tasks:	Transportation to and from social activities, friendly visiting and any activities that the patient enjoys, such as hobbies.
• Escort Tasks:	Accompany the patient to religious services, to visit the physician and, in general, go with the patient providing all required aid.

In a survey of welfare clients to determine their need for home health aides, Lemon and Welches<sup>41</sup> discovered that 715 out of 821 clients (87%) clearly needed attendant care. Of that group requiring care, 64% needed domestic services and 36% needed home health services. Grant<sup>25</sup> also tells of a successful program of the Washington, D.C. Department of Public Health which concentrated on the recruitment, training and supervision of home health aides. In addition to calling attention to the number of new jobs generated by removing inappropriately institutionalized persons into the community, Morris and Harris<sup>32</sup> also raised the issue of training people for those jobs.

ment, the ability to employ people with household skills would be beneficial. Several home health care agencies have already demonstrated their ability by conducting work incentive programs (WIN) to train and employ people on welfare. Community Employment Training Act (CETA) programs also bring new people into home health care. Dr. Philip R. Lee<sup>40</sup>, former federal Assistant Secretary for Health, discussing the removal of barriers to outpatient care, noted: "It is also important to provide payment for nontraditional health workers, such as community health aides who may be able to contribute more to helping patients solve health-related problems than can the highly trained professional."

Home health care programs usually have a physician who takes responsibility for the overall continuity of care for the patient. Chapin<sup>10</sup> lists seven responsibilities of the physician in home care services including supervision of the team of workers, awareness of when to use coordinated home care, referral to services, record keeping and exchanging information with others, consultation when required, discharge of the patient, and adviser to the hospital, medical society and others.

When the tasks involved are categorized under the social model, social workers instead of physicians usually assume the leadership role as in Title XX implementation. Levels of care also determine the skills needed to perform the required tasks. Patients may need intensive care, intermediate care or maintenance care. In each instance, the skills will vary.

Home health care recruitment might start at the professional level where more personnel are needed. It has been suggested that welfare recipients may be a source of potential workers along with the currently unemployed and retired persons, such as policemen, armed forces personnel and other civil servants. One program recruited policemen to work in the health field; others are recruiting former armed forces medical corpsmen to become physicians' assistants.

Once recruited, people have to be trained. The CETA and WIN programs offer training opportunities. Some home health agencies have developed core curriculums for the training of their home health aides and homemakers. Self-



instructional materials have been developed by the armed forces, the Hospital Research and Educational Trust and others that may prove useful in training. With the many types of health workers involved, the problem is to make sure their jobs and training do not overlap with similar or closely-related functions of other workers. Continuing education built around a career ladder to help employees advance to higher skilled and higher paid jobs is an essential part of any plan to expand manpower supply.

### QUALITY OF CARE: STANDARDS AND ENFORCEMENT

Along with licensure, accreditation of programs and agencies is another alternative strategy to certificate of need. Salkever and Bice<sup>77</sup> suggested that more attention to quality care mechanisms should be included along with a critical examination of the need to improve CON. Of course, any quality control effort must also be able to enforce standards to prevent abuse and exploitation.

Accreditation is the process by which a designated organization evaluates and attests that an institution or program of study meets certain standards of administration, physical plant, scope and organization of services, including staffing, records and community relations. Many involved in home health care regard the voluntary joint accreditation program of the National League for Nursing and the American Public Health Association<sup>64</sup> as representing the optimum standards of quality care.

In early 1977, Home Health Services of Louisiana became the first home health agency accredited under the NLN-APHA standards<sup>68</sup>. If this level of accreditation is established as the norm, the federal government might consider accepting it as certification for reimbursement, just as it does for the standards of the Joint Commission on Accreditation of Hospitals.

Standards have been developed for the homemaker-home health aide by the National Council for Homemaker-Home Health Aide Services, Inc.<sup>57</sup>, along with supplementary services guidelines<sup>61</sup>. These standards are widely accepted.

In addition, the Joint Commission on Accreditation of Hospitals<sup>36</sup>, widely respected for its regulatory activities, has a section of standards for hospital-based home care programs in its accreditation manual. This home care section includes standards for administration, organization, medical staff responsibilities, personnel and qualifications, program review and evaluation, clinical records and community participation.

Witnesses testifying at the five regional public hearings<sup>66</sup> were united in their call for quality assurance. More than half of the witnesses expressed this concern and identified the following problems:

- Inherent difficulties in assuring the delivery of quality care in the home.
- Variability in quality of care under the differing standards of existing support programs.
- Importance of clearly defined, measurable, and enforceable standards for personnel and institutions.
- Need to protect both the patient receiving services and the public's tax dollars from abuse and exploitation.

Quality assurance in the home is particularly difficult because workers in so many locations cannot be easily supervised. Monitoring of care will, therefore, require costly, on-site observations. Furthermore, since the diseases being treated tend to be chronic, incurable and interrelated, it is difficult to separate them.

Evaluations should reflect the patient's ability to function and meet the activities of daily living. Because of the diseases or conditions involved and the realistic expectation that changes in health status may be slight, evaluation should not concentrate on a narrow definition of health status changes.

Some of the difficulty with quality control activities in home health care programs relates to the concepts of "curing" and "caring." Howell<sup>30</sup> equates curing with the technological aspects of health care and caring as more closely related to the art of healing. Measurements of caring usually use the following indicators: satisfaction, the effects on family members, compliance with treatment regimens, and broken appointments. The qualifications of a physician who handles home care patients are succinctly stated by Alex<sup>2</sup>: "Not only must he be thoroughly qualified professionally, but he must have warmth, understanding, a feeling for people, sensitivity, empathy, and ability to understand chronic illness and its impact upon people and families." He must be able to work with other professional groups. He is practicing "medicine with a heart." Philosophical concerns about caring should be part of the basic and continuing education of health professionals and other health workers.

Physicians and others in positions of making referrals to home health care services must be knowledgeable about those services. Physician referral failure was pointed out by Nash and Arno<sup>55</sup> who noted that 58 out of 100 elderly patients were not referred to home care by physicians. Of those 58 patients, 33 were judged to need home care and 10 others required hospitalization. In non of those 43 patients was an appropriate referral made by a physician. Furthermore, their study of 2,652 referrals in 1974 showed 36% were by friends, family and community agencies, 32% by hospitals, and only 18% by physicians. Nash<sup>54</sup> believes that the main problem is to educate physicians. A survey of a local medical society revealed that those physicians who knew about the home care services evaluated them favorably, whether they used them or not.

Quality assurance in home health care could be linked to existing mechanisms for quality control such as Professional Standards Review Organizations, utilization review committees, medical care evaluations and governmental review bodies. PSRO guidelines exist for about 300 diseases and conditions. It may be possible to proceed in a similar fashion in developing baseline norms, standards and criteria for use by home health care agencies. The PSRO model might be adaptable.

A movement in this direction is supported by research studies such as Stone's<sup>66</sup> that showed the results of health care were not statistically different for a random group of general hospital patients, regardless of whether they were treated in the home or the hospital. Neither diagnosis nor prognosis made a difference in the end results at the level of care tested, and physicians and patients strongly preferred home care. Nielsen<sup>67</sup> reported that it was statistically significant that fewer patients in his home care group of geriatric patients were

admitted to long-stay institutions. Patients also had fewer days stay in those institutions with no difference in survival rates. Home care patients, particularly those with fractures, arthritis and stroke, had a tendency toward higher levels of contentment. In its review of patients discharged from home health agencies in 1974, the Massachusetts Department of Public Health<sup>46</sup> showed that 75% of the patients remained at home after care was completed, 19% had to be readmitted to an acute care hospital, and only 2% had to be readmitted to a nursing home.

Many of the factors in current evaluations of health care quality have limited application to home health. As Spiegel and Backhaus<sup>43</sup> note, most of the norms, standards and criteria do not include measurements that deal with the caring aspects of health care. These types of evaluations would be particularly pertinent for home care patients, since the changes in health status could be minor.

Under the federal government auspices, a series of monographs are being developed that deal with evaluating six identified components of a health care system. These components should apply to the home health care system, for example:

- Is access to services equitable, easy, affordable to all?
- Are services *acceptable* to groups with varied sociocultural backgrounds?
- Are services *available* within the geographic community?
- Is *continuity* of care provided with someone responsible for the patient?
- Is the cost reasonable while still maintaining high quality care?
- Is the *quality* of care up to standards set by experts?

A commonly used quality measurement topology divides health care into three elements for consideration: structure, process, and outcome. Examples of the components of each are illustrated below:

**Structure:** Facilities, equipment, staffing patterns and job descriptions, personnel with qualifications and experience requirements, organizational arrangements and financing mechanisms.

**Process:** Technical competence of the providers judged primarily by peers or by accepted standards of care, patient behavior as it influences care.

**Outcome:** Changes in health status that are reflected in mortality and morbidity rates, disability limitation, distress and dissatisfaction measures.

A major investigation of quality control is underway to try to find relationships between structure, process and outcome. Some believe outcome may not be affected by structure or process and may depend more upon genetics, for example.

Witnesses appearing at the 1976 Regional Public Hearings<sup>46</sup> overwhelmingly endorsed the need for increased and improved quality assurance and standards with emphasis upon expanded and coordinated services of high quality in a continuum of comprehensive care.

Protection against abuse and exploitation is directly linked to the enforcement of elements such as licensure, accreditation and standards. Spiegel and Podair<sup>42</sup> explicitly detail a variety of

monitoring methods, utilization review techniques and medical record auditing activities used in medicaid. A key factor in preventing abuse is the manpower needed to enforce the quality guidelines. In addition, the required legal and political power to carry out rigid enforcement has at times proved problematical. Without enforcement, quality control of home health care will remain in never-never land.

As one focuses on the consumer movement in the health field generally, one advocates that consumers of home health care should play a larger role in determining the quality of care. Van Dyke and Brown<sup>45</sup> advocated the involvement of patients on a consumer advisory committee of home health care agencies. For consumers of home health care, many of the measurements would necessarily deal with elements that are difficult to evaluate in terms of satisfaction. At times, the satisfactions of professionals are also measured as part of the quality control effort.

Allen<sup>3</sup> reported on the sources of dissatisfaction of professionals associated with home health agencies especially factors affecting home care referrals. Dissatisfaction was expressed with the quality of home care, with the lack of feedback about patients, with transportation services, with emergency assistance for patients and with the lack of support from the administration on home care referrals, even though quality was rated high on responses.

## COST CONTAINMENT AND COST EFFECTIVENESS

*We've hardly scratched the surface as far as exploiting health care at home as a cost-saving device. Home visits directed by a physician/nurse team can save dollars and provide good care in a good setting. What's required is for physicians to support this activity more widely than they do at present.<sup>49</sup>*

Home health care can be a cost effective method at many levels of care. Its expansion should be encouraged by larger allocations of federal and state health budgets. There are many illustrations that show home health care has reduced patient need for expensive acute hospital care. The illustrations come from insured home care programs, hospital-based programs, and health maintenance organizations (HMOs). Some 113,000 days were saved by the limited home health care benefits of New York Blue Cross<sup>5</sup>. Denver Health and Hospitals early discharge program reduced hospital stays by 19.2 days per patient<sup>45</sup>; and a Portland HMO home health care program reduced acute hospital stays from an average of 5.4 days to 4.9 days<sup>40</sup>. As for long-term care, the Congressional Budget Office<sup>13</sup> says: "there is evidence that 20 to 40 percent of the nursing home population could be cared for at less intensive levels where adequate community based care is available."

If the presumption can be made that unit costs of home care compared to unit costs of acute care and, often, nursing home care are less expensive, then a number of questions are raised. Why do third-party payers including medicare and medicaid limit home health care use so severely? Why do physicians and hospitals make relatively little provisions for cost saving home health care in treatment plans? Why do private insurers and their premium payers including businesses, unions, local governments and individuals demand so

little home care? Why do HEW planners make so little effort to place home health care higher on the agendas of HSAs?

The response seems to be a fear of the aggregate costs of taking patients away from hospitals and nursing homes, or overutilization of home health care, of expansion of home health care by the addition of more social services to the medical services, and of destructive competition through uncontrolled proliferation of home health care providers. Clarification should tell which fears are groundless and show where and how to be on guard against genuine dangers.

Many see CON as a means of protection against cost increases. All too frequently, CON has been looked upon as though it were a proven method of cost containment that could be applied to home health care. On the contrary, as Salkever and Bice<sup>77</sup> have concluded, "While the composition of hospital investment is altered by CON, the total level of investment is not reduced . . . These findings are at variance with the presumption that inflation in the costs of hospital services can be reduced substantially by CON controls on hospital investment."<sup>78</sup>

They have urged rate review and PSROs be considered as potentially more useful for cost containment. At the institutional level, cost containment techniques that appear to work in the short run, involve the crude method of reducing labor costs by attrition or by layoff and government wage and price controls. These are all outside the scope of both CON and HSAs.

Furthermore, CON may be mistakenly thought by some to address cost effectiveness, which it does not. CON is not a monitoring mechanism as rate setting and PSROs are. CON does not explicitly deal with quality and manpower. The concept of cost containment is related, but not identical to cost effectiveness. Only the concept of cost effectiveness goes beyond containment and links cost to the quality of care and the impact on the patient.

Michigan's Office of Services for the Aging<sup>51</sup> in a report to Governor Millikan has recognized that the types of services available are a major influence on cost. The report contends that in northern states, the reliance is on hospitals and nursing homes—with no evidence of a shift in emphasis to home health care. In contrast, they have found southern states are coping with heavy use of health and social care by the elderly with increased use of in-home, outpatient and community services. The Michigan report contends that this is happening in southern states because, "they can no longer afford the higher cost options and personal choice is predominantly for care in one's own home."

In advocating a substantial increase in home health care, the Michigan report<sup>51</sup> recounted the institutional dislocation and cost shifts that could follow:

*As there is greater reliance upon in-home and community services, there should be a decreased reliance upon institutional services, hospital services in particular. The effect is likely to be a declining hospital population, increased per capital costs for hospital services, and subsequent increases in reimbursement rates. If this issue is not addressed, and alternative care services are developed, it is near certainty that the aggregate costs for health/social care will increase at a greater rate than at present.*

The danger is real; however, the burden may be misplaced. Given the documented extraordinary costs of hospitalization

and the generally acknowledged inappropriate placements in hospitals and nursing homes, the burden should be on these institutions to prove that, at the very least, continued institutionalization is an alternative to home health care. The hypothesis could be advanced that one reason for restricting the expansion of home health care is that no way has been found to offset the expenditure by a reduction in spending for often inefficient institutional care. In terms of long-term care, the Congressional Budget Office<sup>13</sup> has been blunt: "Public programs disproportionately support nursing home care. Less than 10 percent of public funds are for home based services . . . If all services were readily available, the distribution of the disabled and elderly among levels of care would be quite different from its present distribution. There is a large, unmet demand for sheltered living arrangements, congregate housing, and home health care."

In one of the most methodologically sound studies, Greenberg<sup>24</sup> estimated 9% of the 1974 Minnesota nursing home population could be cared for less expensively at home. He found that only at the worst disability level is home care as or more expensive than nursing home care. The Congressional Budget Office<sup>13</sup> has noted the danger of a net cost increase by deinstitutionalizing patients and providing them with home health care without considering restructuring long-term care.

*Despite evidence of possible savings from deinstitutionalizing some present nursing home residents, the number of the noninstitutionalized disabled who are bedridden or need personal care assistance is so great that patients removed from nursing homes would be quickly replaced. Moreover, home health services, if not limited to those who had first been institutionalized, would be demanded and needed by so many of the noninstitutionalized disabled that there would be a net increase in expenditures.*

The evidence is far stronger on the hospital side that home health care could be used without replacement of patients in hospitals. How hospitals and nursing homes cope with the financial loss of patients will be one factor in assessing the rate of increase in the nation's health care costs.

The total costs of health care will increase in any event as a higher proportion of our population becomes elderly and suffers from chronic disease. However, home health care may be able to slow the rate of increase. A substitution of home health care for hospital and nursing home care would seem to meet patient preferences while lowering cost to third-party payers.

The Michigan report<sup>51</sup> recognized the need for a definition that can provide a balance and prevent abuse.

*Additionally, while the report continually refers to possible cost savings, in no way is it suggested that cost savings automatically occur when lower unit cost services are made available. For example, reimbursing a family \$16 per day to care for a 'mom,' rather than pay \$20 a day to a nursing facility would not save program dollars if nine other families who would care for their 'mom' without reimbursement now apply for and receive membership in the program.*

Despite such dangers, many reports come out strongly for home health care, not only as an alternative to acute care, but as an alternative to nursing home care. One strong cost argument in favor of such care compared to nursing home care is stated this way.



*Just as significantly when discussing costs, home care can be phased out or lessened for many people over time, while nursing home care usually results in dependency and continual use until death. Thus, even if temporary home health or home service costs are not truly 'cheaper' to the State for the first few days compared to a nursing home, they very likely will be over a longer period.<sup>51</sup>*

The favorable comparisons between institutional care and home health care make the further expansion of home health care an important policy direction. Present government policies are restricting that expansion. Medicare requires 3 days of prior hospitalization before granting eligibility for home health care. Medicare Part A also restricts the number of home health visits to 100. While the federal medicaid regulations are on the surface more liberal, these regulations permit states to use medicare eligibility requirements for medicaid, which many have. If government planners are serious about cost effectiveness, they must consider an expanded definition of home health care need that permits greater access and, at the same time, balance it by requiring enforcement to prevent abuse.

A distinction needs to be made between two views of cost effectiveness: cross-institutional comparisons of home health care, usually with a hospital or nursing home (which have just been examined) and comparisons among home health providers (which will be reviewed).

The comparisons of cost effectiveness among home health care providers pose many methodological problems, which make it impossible to draw firm conclusions. One key need is to develop uniform reporting<sup>58</sup> of costs and services so that firm conclusions can be drawn. Failure to provide for uniform reporting will further complicate attempts to assess cross-institutional cost effectiveness.

Provider financial reports rarely show what was included or excluded in the cost calculation. It is not possible to tell whether capital costs, professional services applied by another body, such as a public welfare department, or physicians' fees were included. There are also no longitudinal studies that could provide a basis for judgments on the duration of care from year to year. Neither is financial and statistical data linked to the intensity, duration, or complexity of the services rendered.

Meanwhile, rough comparisons are being made between not-for-profit agencies, proprietary ones, and among established and newer not-for-profit agencies. Florida<sup>104</sup> found a wide range of costs and staffing ratios among not-for-profits. It also found that so many not-for-profits had relatives on the board that the recommendation was made to set a limit to two relatives per board. Etzioni<sup>119</sup> examined the legally permissible but no less unethical abuses that some established and new not-for-profits in health are able to get away with because of their structure. These small numbers of abuses are tainting the good works of the vast not-for-profit area. On the other hand, there have been findings among proprietary providers that suggest excessive billings to medicare for lavish comforts of the providers. A number of other serious scandals have broken out among proprietary providers. What these findings reveal on the cost issued is that agency auspices is not a useful way of examining cost, and may, in fact, be irrelevant. If any generalizations can be made, it will after more uniform cost reporting.

The expansion of home health care is warranted on cost grounds based on the present federal and state definitions of need. Decision makers considering expanded definitions of need for federal and state reimbursed services will find, as the Congressional Budget Office has, that the area of unmet need is frequently in home health and not in new institutional care.

## BIBLIOGRAPHY

1. Abdelah, F.G. HEW Task Force Examines Ways to Upgrade and Expand Home Health Care Programs. *Geriatrics*. 31:43, 1976.
2. Ales, M. Medical Care in *The Physician Speaks on Home Care*. DHEW Pub. (PHS) 1954, 1966.
3. Allen, D.V., Kuhns, P.L., Werley, H.H., Peabody, S.R. Agencies: Perceptions of Factors Affecting Home Care Referral. *Medical Care*. 12:828, 1974.
4. Azcoli, R. The Urological Treatment of Paraplegic Patients at Home. *Paraplegia*. 12(4): 260, 1975.
5. Associated Hospital Service of New York. Excerpts from Home Care Following Hospitalization. New York, 1965.
6. Bicknell, J. and Walsh, D.C. Certification of Need: The Massachusetts Experience. *New England Journal of Medicine*. 293:1054, 1975.
7. Brickner, P.W., Duque, T., Kaufman, A., Sarg, M., Jahre, J.A., Maturlo, S., Janeski, J.F. The Homebound Aged: A Medically Reachable Group. *Annals of Internal Medicine*. 82:1, 1975.
8. Bryant, N. et al. Comparison of Care and Cost Outcomes for Stroke Patients With and Without Home Care. *Stroke*. 5:54, 1974.
9. Burch, G.E. A Need for More Care at Home. *American Heart Journal*. 89:402, 1975.
10. Chapiro, S.E. The Professional Community in Home Care in *The Physician Speaks on Home Care*. DHEW Pub. No. (PHS) 1954, 1966.
11. Cohen, S. Professional Licensure, Organizational Behavior and the Public Interest. *Milbank Memorial Fund Quarterly*, 51:73, Winter 1973.
12. Cohen, S. Regulatory Politics and American Medicine. *American Behavioral Scientist*. 19(1): 1975.
13. Congressional Budget Office. *Long Term Care Report*. February 18, 1977.
14. Correia, E. Public Certification of Need for Health Facilities. *American Journal of Public Health*. 65:260, 1975.
15. Dahl, R.A. *A Preface to Democratic Theory*. Chicago: Univ. of Chicago Press, 1956.
16. Denver Department of Health and Hospitals, Savings to Medicare Programs as a Result of Early Hospital Discharge Program 1/1/70 - 12/31/70.
17. Dunleavy, E. Occupational Therapy in Home Health. *American Journal of Occupational Therapy*. 28:484, 1974.
18. Eddington, C. et al. Sensory-Motor Stimulation for Slow-to-Develop Children. A Home Centered Program for Parents. *American Journal of Nursing*. 75(1): 59, 1975.
19. Etzioni, A. and Doty, P. *Profit in Not-for-Profit Institutions*. Center for Policy Research. Columbia University, New York City. January, 1976. Mimeo.
20. Fischhoff, E. Homebound Dentistry. *Annals of Dentistry*. 31:14, 1972.
21. Friesen, H. A Home Care Program for Respiratory Patients. *Canadian Hospitals*. 50:40, 1973.
22. General Accounting Office. *Home Health Care Benefits Under Medicare and Medicaid*. Report to the Congress No. B-164031 (3), July 9, 1974.
23. Gerson, L.W. and Hughes, O.P. A Comparative Study of the Economics of Home Care. *International Journal of Health Services*. 6(4):543, 1976.
24. Greenberg, J. The Costs of In-Home Services, in the Governor's Citizens Council on Aging. *A Planning Study of Services to Non-institutionalized Older Persons in Minnesota*, Minneapolis, Minnesota, 1974.
25. Gram, M. Health Aides Add New Dimension to Home Care Program. *Hospitals*. 40:63, 1966.
26. Haber, P.A.L. Hospital-Based Home Care After Myocardial Infarction. *Geriatrics*. 30:73, 1975.
27. Havighurst, C. Government's Increasing Involvement in the Health Care Sector: The Hazards of Regulation and Less Hazardous Alternatives in *The Changing Role of the Public and Private Sector in Health Care*. National Health Forum. Chicago, Illinois. March 20-21, 1973.
28. Hiestand, I. Pluralism in Health Services in E. Ginsberg (ed) *Urban Health Services*. Columbia U. Press, New York City, 1971.
29. *Home Health Line*. The Bennett Group/Health Services, 407 N Street, S.W. Washington D.C. 20024. Various issues. October, 1976 to February, 1977.
30. Howell, J.R., Osterweis, M., Huntly, R.R. Caring and Caring - A Proposed Method for Self-Assessment in Primary Care Organizations. *Journal of Community Health*. 1(4):256, 1976.
31. Howlin, P. et al. A Home Based Approach to the Treatment of Autistic Children. *Journal of Autism and Childhood Schizophrenia*. 3:308, 1973.
32. Hyman, H.H. *Health Planning. A Systematic Approach*. Germantown, Md.: Aspen Systems Corporation, 1975.
33. Hyman, H.H. *Health Regulation. Certificate of Need and 1122*. Germantown, Md.: Aspen Systems Corporation, 1977.
34. International Council of Home Help Services. Information Bulletin No. 11 Utrecht, Holland, June, 1975.
35. Isak, F.C. et al. Comprehensive Rehabilitation of the Patient With Cancer. Five Year Experience of a Home-Care Unit. *Journal of Chronic Diseases*. 26:363, 1973.
36. Joint Commission on Accreditation of Hospitals. *Accreditation Manual for Hospitals*. Chicago, 1976.
37. Jones, M. Certificate of Need Legislation for Home Health Agencies in New York State in *State Organization Planning for Home Health Care*. National League for Nursing: New York City. 1976. pp. 1-9.
38. Langer, B. et al. Prolonged Survival After Complete Small Bowel Resection Using Intravenous Alimentation at Home. *Journal of Surgical Research*. 15:226, 1973.
39. Lawson, I.R. The Teaching of Chronic Illness and Aging in Home-Care Settings in *Teaching of Chronic Illness and Aging* edited by D. W. Clark and T. F. Williams. DHEW Pub. No. (NIH) 75-876, 1976.
40. Lee, P.R. quoted in *Humanizing Health Care* edited by J. Howard and A. Strauss. N.Y.: John Wiley & Sons, 1975. page 311.
41. Lemon, G.M. and Welches, L. Survey of Welfare Clients to Determine Need for Home Health Aides. *Public Health Reports*. 82:729, 1967.
42. Lewin and Associates, Inc. *Evaluation of the Efficiency and Effectiveness of the Section 1122 Review Process*. Washington, D.C. September, 1975.
43. Lowi, T.J. *The End of Liberalism - Ideology, Policy and the Crisis of Public Authority*. New York: W.W. Norton and Co., Inc., 1969.
44. MacLennan, W.J. The Young Chronic Sick at Home and In Hospital. *Health Bulletin* (Edinb) 30:110, 1972.
45. Macro Systems, Inc. *The Certificate of Need Experience: An Early Experience*. Volume I: Summary Report. Silver Springs. Maryland. April, 1976.
46. Massachusetts Department of Public Health. Clients of Home Health Agencies. *New England Journal of Medicine*. 293:1261, 1975.
47. Mather, H.G., Morgan, D.C., Pearson, N.G., Read, K.L.Q., Shaw, D.B., Stead, G.R., Thorne, M.G., Lawrence, C.J., Riley, I.S. Myocardial Infarction: A Comparison Between Home and Hospital Care for Patients. *British Medical Journal*. 1:925, 1976.
48. McCarthy, E. Comprehensive Home Care for Earlier Hospital Discharge. *Nursing Outlook*. 24:625, 1976.
49. McKenzie, L.L. et al. Medical, Economic and Social Impact of a Home Therapy Program for Hemophilia A on Selected Patients. *Southern Medical Journal*. 67:555, 1974.
50. Merlin, D. Home Care Project for Indigent Allows Dignified Care, Cut Costs. *Hospitals*. 49:77, 1975.
51. Michigan Office of Services to the Aging. *Alternatives to Institutional Care*. Lansing, Spring, 1976.
52. Morris, R. and Harris, E. Home Health Services in Massachusetts: Their Role in Care of the Long Term Sick. *American Journal of Public Health*. 62:1088, 1972.
53. Murray, J.T. et al. A Study of the Contribution of the Health Visitor to the Support and Care of Terminally Ill Patients and Their Relatives. *Health Bulletin* (Edinb) 32(6):250, 1974.
54. Nash, D.T. Making Use of Home Health Services. *Geriatrics*. 29:140, 1974.
55. Nash, D.T. and Arno, J.T. Physician Referral Failure. Study of Home Care. *New York State Journal of Medicine*. 76:45, 1976.
56. National Association of Home Health Agencies. *Home Health Review*. St. Louis, Missouri, February, 1977.
57. National Council for Homemaker-Home Health Aide Services, Inc. *Homemaker-Home Health Aide Services. Approval Program*. N.Y., 1971.
58. \_\_\_\_\_. *Costs of Homemaker-Home Health Aide and Alternative Forms of Service*. N.Y., 1974.
59. \_\_\_\_\_. *A Better Answer-Alternatives to Institutional Care* (paper by J. Starr) N.Y., 1975.
60. \_\_\_\_\_. *Homemaker-Home Health Aide Services to the Mentally Ill and Emotionally Disturbed - A Monograph*. N.Y., 1977.
61. \_\_\_\_\_. *Supplementary Services Guidelines*. N.Y., 1977.
62. National League for Nursing. *Type, Length and Cost of Care for Home Health Patients*. N.Y.: 1975. 821-1589.
63. \_\_\_\_\_. *Proposed Model for Home Health Care Benefits*. N.Y., 1976. 821-1614.
64. \_\_\_\_\_. *Accreditation of Home Health Agencies and Community Nursing Services*. N.Y., 1976. 821-1612.
65. \_\_\_\_\_. *State Organization Planning for Home Health Care*. N.Y., 1976. 821-1629.
66. \_\_\_\_\_. Position Statement on Certificate of Need. Sept. 28, 1976 (mimeo).
67. Nielson, M., Blemker, M., Bloom, M., Downs, T., Beggs, H. Older Persons After Hospitalization: A Controlled Study of Home Aide Service. *American Journal of Public Health*. 62:1094, 1972.
68. O'Leary, F. Certificate of Need: The Bridge Between Health Care Planning and Implementation. *View Point*. Health Insurance Council, New York, July, 1972. pp. 1-8.
69. *Patient Care*. Cost Cutting Pearls from Reader Reviewers. 11(4): Feb. 15, 1977.
70. Polsky, N.W. *Community Power and Political Theory*. New Haven, Conn.: Yale Univ. Press, 1963.
71. Rae, A. et al. Home Dialysis: Its Costs and Problems. *Canadian Medical Association Journal*. 106:1305, 1972.
72. Raskin, D.E. Referral to a Home Care Programme. *International Journal of Social Psychiatry*. 19:88, 1973.
73. Robinson, N. et al. Cost of Homemaker-Home Health Aide and Alternative Forms of Service. National Council for Homemaker-Home Health Aide Services, 1974.
74. Rose, M.A. Home Care After Peripheral Vascular Surgery. *American Journal of Nursing*. 74:260, 1974.
75. Ryder, C.F., Slitt, P.G., Elkin, W.F. Home Health Service-Past, Present, Future. *American Journal of Public Health*. 59:1720, 1969.
76. Ryder, C.F. In-Home Care - Towards a National Policy and Strategy in *Community Health - Strategies for Change* distributed by the National League for Nursing. N.Y., 1973.
77. Salkever, D.S. and Bice, T.W. *Impact of State Certificate of Need Laws on Health Care Costs and Utilization*. DHEW Pub. No. (HRA) 77-3163, 1977.



78. Somers, P. State Regulation of Hospitals and Health Care: The New Jersey Story. *Blue Cross Reports: Research Series* 11, Chicago, Illinois, July, 1973.
79. Somers, A.R. and Bryant, N.H. Home Care: Much Needed, Much Neglected. *Annals of Internal Medicine*, 82:111, 1975.
80. Somers, A.R. and Moore, F.M. Homemaker Services - Essential Options for the Elderly. *Public Health Reports*, 91:354, 1976.
81. Soyka, P.W. Homemaker-Home Health Aide Services for Handicapped Children. *Child Child Welfare*, 55:241, 1976.
82. Spiegel, A.D. and Podair, S. *Medicaid: Lessons for National Health Insurance*. Germantown, Md.: Aspen Systems Corporation, 1975.
83. Spiegel, A.D. and Bachhaus, B. *Factors Affecting the Quality of Health Care*. Rockville, Md.: National Health Planning Information Center, 1977.
84. Spohn, R. *Testimony on Issues in Home*. Department of the Aging, The City of New York. Presented before DHEW at 26 Federal Plaza, New York City. September 20, 1976.
85. Stein, M.H. The Pharmacist's Role in Home Health Care. *American Journal of Pharmacy*, 145:146, 1973.
86. Stone, T.R., Patterson, E., Felson, L. The Effectiveness of Home Care for General Hospital Patients. *Journal of the American Association*, 205:95, 1968.
87. Sunday News. Offer 24-Hour Home Care for Terminally Ill and Kin. Feb. 20, 1977.
88. The Nation's Health. Home Health Agency Wins First Joint Accreditation. Newspaper published by the American Public Health Association, Feb., 1977.
89. Trager, B. Home Care: Providing the Right to Stay Home. *Hospitals*, 49:93, 1975.
90. Trager, B. *Homemaker-Home Health Aide Services in the United States: Determining need*. HEW, Health Services Administration, Bureau of Community Health Services, DHEW Publication No. HSM 73-6407. June, 1973.
91. Tricot, A. et. al. Home Care of the Spinal Injury Patient. *Paraplegia*, 12(4):254, 1975.
92. Truman, D.B. *The Governmental Process - Political Interest and Public Opinion*. New York: Alfred J. Knopf, 1951.
93. U.S. Congress. *Public Law 93-641*, 93rd Congress, S. 2994. January 4, 1975.
94. U.S. Congress. *HEW Health in the Later Years of Life*. Pub. No. (HSM) 72-1207, 1972.
95. \_\_\_\_\_. *Health. United States*, 1975. Pub. No. (HRA) 76,1232, 1976.
96. \_\_\_\_\_. *Home Health Care. Report on the Regional Public Hearings*. Sept. 20, Oct. 1, 1976. Pub. No. 76-135, 1977.
97. \_\_\_\_\_. *Health Planning: Capital Expenditure Review, Certificate of Need, and Review of New Institutional Health Services*. Federal Register. Jan. 21, 1977, pp. 4002-4032.
98. \_\_\_\_\_. *Home Health Care: A Discussion Paper by the Inter-Departmental HHC Policy Working Group*. Office of the Secretary. December, 1976. Mimeo.
99. \_\_\_\_\_. *Health Systems Agencies: Designation and Funding*. Federal Register. March 26, 1976. pp. 12812-12834.
100. \_\_\_\_\_. *Guidelines Concerning the Development of Health Systems Plan and Implementation Plans*. Bureau of Health Planning and Resources Development, HRA. Dec. 23, 1976.
101. U.S. Senate Special Committee on Aging. *Alternatives to Nursing Home Care: A Proposal*. October, 1971.
102. \_\_\_\_\_. *Home Health Services in the United States*. April, 1972.
103. \_\_\_\_\_. *Nursing Home Care in the U.S.: Failure in Public Policy*. December, 1974.
104. Wemlund, M. Position Paper on Home Health Issues. Division of Health, State of Florida, 1974.
105. Van Dyke, F. and Brown, V. Organized Home Care: An Alternative to Institutions. *Inquiry*, 9(2):3, 1972.
106. Vladeck, B.C. Interest-Group Representation and the HSAs: Health Planning and Political Theory. *American Journal of Public Health*, 67:23, 1977.
107. Wilkes, E. How to Provide Effective Home Care for the Terminally Ill. *Geriatrics*, 28:93, 1973.
108. Yanover, M.J., Jones, D., Miller, M.D. Perinatal Care of Low-Risk Mothers and Infants. *New England Journal of Medicine*, 294:702, 1976.

## ACKNOWLEDGEMENTS

We want to thank those who have been helpful in the preparation of this monograph. At Hunter College: Dr. Peter D. Salins, Dr. Robert C. Weaver and Elinor Rubin. We were particularly fortunate to receive viewpoints, references or information from the following people holding divergent opinions: Stephen Beaudry, Joint Commission on Accreditation of Hospitals; Dr. Philip Brickner, St. Vincent's Hospital; Rose Caserta, National League for Nursing; Steve Crystal, NYC Human Resources Administration; Jane Leiken, Bergen-Passaic Health Systems Agency; Joseph Maniscalco, Group Health Insurance's Home Health Services; Mary Major, NYC Department of Aging; Robert O'Connell, US Department of HEW, Region 11; Simon Podair, Mayor's Office of the Handicapped; Ronald Rosenberg, Homemakers Upjohn; Mary Walth, National Council for Homemakers-Home Health Aide Services, Inc.

Of course, all the views expressed are the authors' responsibility and do not represent a position of Hunter College or its Urban Research Center.

Mr. ROGERS. Without objection, it will be included.

Of course, you know, we already have home health care, medicare. What this would do is simply authorize a certificate of need, so that if there is a need, I presume the certificate would be issued. If there is not, then that is a different matter, but I don't think you really have home health care simply to say people should come in to show the need.

Do you anticipate that certificate of need stops everything, or just those that are not needed?

Mr. NORRIS. We feel that it certainly impedes many things until the need has been filled, and when a need has been filled, we can then set up criteria to measure need. We think that, at this point, that home health care is too new. It is a baby, so to speak, and until we have criteria, until we have numbers, there is no way, at the present time, to measure need in home health care.

Mr. ROGERS. You say yourself 90 percent of the country needs it. I would think the need would be very easy to prove. If there is no home health service in the area, I would think you would have to have a certificate of need.

Mr. NORRIS. That is not our problem, or really our question. We are saying a home health agency, in a given area, does not provide competition, and will not fill the need. We hope it would open it up for everyone to become involved in the delivery of home health care.

Mr. ROGERS. I think one of the problems the committee is concerned with is that we not proliferate, there is no point in having additional costs to the form of delivery. If there is a need, of course, it should be filled, and hopefully, with local—

Mr. NORRIS. We certainly agree.

Mr. ROGERS. I understand your feeling.

Mr. NORRIS. There are areas, of course, in the country today, where we are involved, and we don't if it is an expensive service because we are not reimbursed at the present time in most areas, and do not provide title 18 medicare services.

Mr. ROGERS. Medicare pays on a cost basis, actual costs, and some of those costs, in some areas, are unbelievable.

We had examples given to us where they paid for everything you can imagine—the building, they paid for the director's luncheons and weekend stays, they paid for the Mercedes Benz to ride around in, and we thought the certificate of need might look at that.

Mr. NORRIS. We believe there are other things that will do it at this time, and for the elderly and for the patients who really need the care, we would not then be excluding agencies. We welcome licensing. We welcome strong regulation, monitoring of all of our offices and everyone else's offices that will provide the quality.

Mr. ROGERS. For instance, in some areas, they had very strong visiting nurses associations, and you might want to duplicate that, so I am not sure the certificate of need, if properly administered, that this is an impediment.

Mr. NORRIS. We become involved with many outstanding visiting nurse associations throughout the country. It is interesting, when there is more than one provider, how the other provider improves.

Mr. ROGERS. I don't have any objection to that so long as the need is there, that is fine. I think we understand each other.

Dr. Carter.

Mr. CARTER. Thank you. Are you Mr. Norris?

Mr. NORRIS. Yes.

Mr. CARTER. And you are the president of Homemakers Upjohn. Is that right?

Mr. NORRIS. Yes.

Mr. CARTER. And you are very much for home health care?

Mr. NORRIS. We certainly are.

Mr. CARTER. For chronic diseases. What is the average cost of a trip to the home by one of your medical personnel, your reimbursement from the Federal Government?

Mr. NORRIS. Dr. Carter, that, of course, varies from coast to coast. There are some places, for instance, where we are allowed to provide care under title 18. There are other places in other States where we are not allowed to participate.

Mr. CARTER. Are you allowed to participate in your own State of Michigan?

Mr. NORRIS. In our own State of Michigan, we are not allowed to provide services under medicare or medicaid because the State of Michigan does not license home health agencies. In the State of Kentucky, we are allowed to serve medicare and medicaid.

Mr. CARTER. It is an unusual thing, Mr. Norris. You are the president of Homemakers Upjohn of Kalamazoo, Mich., and you support home health care, and yet you don't have it in your State. Is that correct?

Mr. NORRIS. We do not have the for-profit-oriented home health agencies. Not-for-profit home health agencies in the State of Michigan do provide title 18 and title 19 in the home.

Mr. CARTER. Not-for-profit home health agencies do provide title 18?

Mr. NORRIS. They are allowed to.

Mr. CARTER. What is the cost of one of those visiting nurses for nonprofit?

Mr. NORRIS. This is going to be off the top of my head, and I think it will be close. I am going to say that a visit by a VNA in the State of Michigan for an in-home visit will cost about \$32.50 in that area.

Mr. CARTER. \$32.50?

Mr. NORRIS. Yes, and that is a guess, but I think it is an educated guess.

Mr. CARTER. In Kentucky, since you are very familiar with that, what is the average cost there?

Mr. NORRIS. The State of Kentucky licenses not-for-profit as well as for-profit home health agencies, so we do deliver services there. Again, this is a guess. I am going to say, in the State of Kentucky, a home health visit will be approximately \$25.65.

Mr. CARTER. That has gone up quite a bit in the pasty ear. The last I heard it was, say, \$20.23 for a call, but, you know, you talk about a home visit, \$32.50, that is almost as high as a plumber.

Mr. NORRIS. Just short of it, isn't it.



Mr. CARTER. How many visit does such a nurse or such personnel as you use—do you use doctors up there or just nurses who are part of nonprofit organizations?

Mr. NORRIS. Well, the care would always be delivered under a doctor's orders, but usually by a registered nurse, practical licensed nurse.

Mr. CARTER. I am in the wrong place. I will have to go back home.

Mr. ROGERS. Will the gentlemen yield?

Mr. CARTER. Yes.

Mr. ROGERS. It doesn't do too much good to have competition if you are paid on a cost basis?

Mr. NORRIS. I certainly agree with that.

Mr. ROGERS. That is the way we pay.

Mr. NORRIS. We were not going to talk about reimbursement mechanisms here but, yet, we are opposed to reimbursement on a cost and equity basis, yes.

Mr. CARTER. I would like to get down to the guts of this thing—the expenses, what it actually costs to provide these services.

How many of such calls does a nurse make per day?

Mr. NORRIS. It is going to vary, *it* is going to average, I am going to say, seven.

Mr. CARTER. Seven per day. Is that turned in to your private nonprofit corporation?

Mr. NORRIS. Mr. Carter, I must have misspoken. Homemakers Upjohn has no private not-for-profit corporations, but of those in Michigan delivering those services, all of the not-for-profit home health agencies in Michigan do receive that money directly from whatever agency they are billing, yes, so if it is \$32.50 times seven, they would receive that per day on behalf of that visiting nurse.

Mr. CARTER. And they are nonprofit outfits?

Mr. NORRIS. That is correct.

Mr. CARTER. You know it doesn't cost that much to make those trips, those calls. What do they do with this other money?

Mr. NORRIS. I guess what it means is——

Mr. CARTER. It is nonprofit.

Mr. NORRIS. Well, one of our organizations can do very nicely by renting quarters. If you are going to be reimbursed on cost and equity, then you better have your own building, and then the building expands and expands and you expand your services because you are going to be reimbursed on cost plus equity.

Mr. CARTER. Are you the president of this organization?

Mr. NORRIS. I am.

Mr. CARTER. Private and nonprofit, and you cover the State of Michigan?

Mr. NORRIS. We are a for-profit enterprise.

Mr. CARTER. But you are not allowed to, your group doesn't practice in Michigan—only the nonprofits practice up there?

Mr. NORRIS. We provide services to the private patients to be paid out of the private patient's pocket only, but the medicaid patient is served only by not-for-profit corporations in Michigan.

Mr. CARTER. And they get \$32.50 per call.

What does a private for-profit nurse get?

Mr. NORRIS. Well, because our billings are not on the basis of cost plus equity, if we are going to serve Mrs. Jones in her home with a

registered nurse, we probably would have an hourly charge of \$7, \$8, \$9.

Mr. CARTER. To get down to it, what would a home call cost from your organization?

Mr. NORRIS. A comparable call would cost \$7, \$8, \$9.

Mr. CARTER. That is all you charge, and you are for-profit?

Mr. NORRIS. Yes. I want to be fair here. Let's say that both organizations have to stop at 815 Pine St., to administer a shot of insulin. That would probably cost \$7, \$8, \$9, if we were doing it. The not-for-profit corporation——

Mr. CARTER. Insulin would cost \$7, \$8, \$9.

Mr. NORRIS. If they are going to do the same thing, it is probably going to cost \$31, \$32.

Mr. CARTER. The Federal Government funded through the non-profit organization?

Mr. NORRIS. That is correct.

Mr. CARTER. It looks like you are operating a good free enterprise system that is doing all right.

Mr. NORRIS. Dr. Carter, we would like the opportunity to do those same things delivering services under titles 17 and 18.

Mr. CARTER. It took a long time to get this out. It would beat the tar out of the nonprofit organizations.

Mr. NORRIS. To be fair, yes.

Mr. CARTER. More power to you.

Mr. ROGERS. Thank you for your helpful testimony. We appreciate it.

Mr. NORRIS. Thank you.

Mr. ROGERS. The last witness, and we thank him for his patience is Gifford Johnson who is the president of the American Clinical Laboratory Association.

Your statement will be made a part of the record.

**STATEMENT OF GIFFORD JOHNSON, PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION, ACCOMPANIED BY ROBERT HALPER, GENERAL COUNSEL**

Mr. JOHNSON. I am not certain if it is good or bad to be last. Mr. Rogers, Dr. Carter, committee members.

Yes, my name is Gifford Johnson. I am a businessman. I am here in two capacities. I am the chief executive officer of my company, the American Biomedical Corporation, which is a publicly owned company operating medical laboratories doing business in 12 States with a network of about 40 different laboratories. I am also currently the president of the American Clinical Laboratory Association, which was organized 7 years ago, to speak for the federally regulated independent laboratories.

I have here with me, Mr. Robert Halper, who is general counsel of the American Clinical Laboratory Association.

Because we are federally regulated, ACLA's members come under Federal scrutiny through quality control programs, unannounced inspections, employee proficiency standards, etc. There are many ways by which the quality of our work is judged. Since we are all organized



for profit, we provide these quality laboratory services at competitive prices and that is the key point I want to make here today. We compete. The industry today is very price competitive and for that reason we have brought the best of the free enterprise system, that has made this country great, to the health industry, an industry which is not known for its competitive climate or its efficiency or productivity.

We have submitted a detailed statement on ACLA's position. It has been passed to you, and rather than recite all of that, I would like to cover a portion that is written between pages 3 and 7 of that.

Mr. ROGERS. All right. The statement will be made a part of the record [see p. 1189].

Mr. JOHNSON. Why am I, as a businessman, testifying before this committee, which is concerned with health systems and health planning? Well, I am here to tell you, on behalf of the competitive independent laboratory industry that if you go through with your proposal to subject independent laboratories to planning and certificate-of-need controls, you will eliminate one of the few competitive health care markets that exists and you will destroy one of the few benchmarks of efficiency and productivity in the health care system. You will be turning your backs on one of the remarkable developments in the health care system that offers some glimmer of hope and some prospect for bringing one aspect of the spiralling health care costs under control. The American Clinical Laboratory Association and I personally urge you, as forcefully as we can, to recognize that the independent laboratory sector does not belong in the same category as hospitals, that are reimbursed on the basis of their costs and that have had little incentive to hold down capital expenditures or to emphasize productivity and efficiency. We are not in the same position as other segments of the health care system for we are not reimbursed on cost. Moreover, independent laboratories, wholly dependent on physicians to place orders for laboratory tests, are not like physicians who can, by their ordering of tests for their patients, insure the success of any capital investment they make, whether for CAT scanners or any other equipment which they choose to purchase or lease.

We read and hear from many sources that there is no competition in the health care industry, a host of other people say that if there were competition in this industry, our spiralling health cost problems might disappear. ACLA's mission here today is to proclaim and demand that you listen to this indisputable fact. Competitive is the adjective that describes market in which independent laboratory operate in this country, it has worked, sometimes too well. We are also here today to tell you that while planning may be appropriate to control rising costs in other sectors of the health care industry, this does not mean that independent laboratories should be subjected to the prior approval program since it is clear that the role of independent laboratories in holding down costs is virtually unparalleled in this system. Let's not solve problems mechanically. Since a problem does not exist, independent laboratories should not be brought within the planning system, with its bureaucratic delays and inevitable diminution of competition, any more than a pharmacy, pharmacy chain, manufacturer of medical devices, or other ancillary health care supplier that is competition controlled.

ACLA has submitted a detailed statement indicating many reasons why health planning laws should not apply to independent laboratories. I wish to discuss one of these points with you now. When I authorize the purchase of another piece of expensive laboratory equipment, my business judgment and reputation are at stake. If that decision is erroneous, my company suffers, and I hear about it from my stockholders. Such risk taking is what has made this country's growth and standard of living preeminent among countries of the world. I cannot defer the taking of risks to Government agencies who cannot promptly nor accurately judge whether an innovative contract my laboratory has negotiated with a major industrial corporation for occupational health screening of employees justifies my decision to purchase a piece of expensive equipment. The independent laboratory should not have to compete for a certificate of need against a hospital or other monopolistic entity that may choose for any reason to oppose an independent laboratory's plan to expand.

ACLA is conducting a study of market competition. Let me share with you some of our findings: In all parts of the country, in every marketplace, where independent laboratories compete head to head, and that includes not only metropolitan centers but also virtually all the rural areas of this country where our laboratories provide service through courier pick-ups and other means, the laboratory fees charged to the physician, to the patient or to the third party carrier have remained stable or increased only slightly over the last five years, despite the fact that the costs of labor and supplies have skyrocketed.

Let us take a look at your district, Chairman Rogers:

There are dozens of independent laboratories located in this area, plus some out-of-town labs who offer services there. There are also many hospitals whose laboratories are competing with us by offering laboratory testing for out-patients. I might note parenthetically that hospitals usually have a dual fee structure for laboratory services—hospitals for inpatient testing, another far lower price for out-patient testing, which reflects the competition that hospitals feel from independent laboratories and the consequent need to offer lower prices to their out-patients. ACLA has found that prices for out-patient testing provided by hospital laboratories are often 50 percent less than the prices they charge for the same test when provided to an in-patient.

We have information from three large laboratories doing business in the Broward-Dade County Florida area, including my company which is one of those operating in that area. Records of these three laboratories comparing 1973 to 1977 prices and costs show the following: The average wage paid to a medical technologist rose 40 percent in that 4 year period, thus, our costs for a given commodity have risen about 40 percent.

On the other hand, the prices charged the physician for the most popular tests he ordered for these three laboratories rose an average of 11 percent in that same 4 year period. It is also significant that during this same 4 year period health care costs evidently were increasing at a rate significantly faster than the 40 percent for technologists' wages.

It is easy to enter the laboratory market. Any party can, with sufficient backing, purchase the necessary equipment and open up a laboratory dedicated to quality and service. It is not easy in today's climate to make a profit and compete successfully. Automation has made it possible to standardize and to hold costs down. This process has forced a very competitive pricing effort by independent laboratories and provides the proof that this industry is very competitive.

Let me make this pledge to you: ALCA will work with the committee and the administration to find ways to minimize health care cost increases in the laboratory area. We feel there are medicare policies of reimbursement that tend to perpetuate the high costs of laboratory services and there are adjustments that could and should be made in the mechanics of reimbursement to assure that the government pays approximately the same amount for a laboratory test, regardless of where it is performed. We feel there are some improvements which we can suggest for making field and statistical sampling of the charges being made by physicians' office laboratories and independent laboratories, which would more effectively guard against fraud and abuse. There are other ways we can assist, too.

In conclusion, we ask this committee to look further at the competitive situation among independent laboratories before imposing planning on the market which would clearly dismantle a system that is working. ALCA believes a case has been made that demonstrates that the competitive situation in a free enterprise environment has kept both the prices and price increases of independent laboratories significantly lower than the prices of other largely non-competitive areas of health care. Planning and controls therefore are unneeded here and would be destructive if applied.

Specifically, we would propose the amendment of language in H.R. 10460 as described on page 2 of our full presentation.

Thank you very much.

[Testimony resumes on p. 1204.]

[ACLA's position paper follows:]





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STATEMENT OF THE AMERICAN  
CLINICAL LABORATORY ASSOCIATION  
ON H.R. 10460 -  
THE HEALTH PLANNING AND RESOURCES  
DEVELOPMENT AMENDMENTS OF 1978  
FEBRUARY 2, 1978

The American Clinical Laboratory Association, an organization of independent, federally regulated, proprietary clinical laboratories, appears here today to urge the Subcommittee on Health and the Environment to amend § 218(b)(3) of H.R. 10460 to exempt the purchases of major medical equipment by independent clinical laboratories from the definition of major medical equipment purchases subject to the prior approval requirements proposed by § 218(a).

Summarized, ACLA's reasons for seeking this amendment are as follows:

- 1) Independent laboratories are one of the few components of the health care industry that operate in competition. This competition regulates major medical equipment purchases more effectively and efficiently than a planning agency could.
- 2) Subjecting the major medical equipment purchases of independent laboratories to prior approval requirements will inevitably reduce the number of active laboratory competitors and will increase concentration within the market. This concentration will lead to increasing prices and decreasing services.
- 3) Independent laboratories are not geographically limited. They have the capability to accept specimens from many states. More than 1000 laboratories currently test specimens that originated in states other than the laboratories' home state. Thus, independent laboratories are not appropriately subject to planning which operates on a regional basis as such regulation would be (a) futile and (b) inapplicable to the realities of the industry.
- 4) Independent laboratories, like pharmacies, provide ancillary rather than primary services. Independent laboratories should therefore be treated like pharmacies and not subjected to planning.
- 5) Since independent laboratories are charge reimbursed, not cost reimbursed, they bear the risk of unwise major medical equipment purchases. No third party carrier picks up the costs incurred by independent laboratories. Therefore, review of the costs

they assume is not necessary. These labs cannot pass on the costs of unwise investments as their prices are set in a competitive market and they are charge reimbursed.

(6) Adoption of an amendment exempting independent laboratories from prior approval requirements will not adversely affect quality since the exemption would only apply to Medicare Certified Laboratories.

(7) Expanding the jurisdiction of health planning agencies to include independent laboratories will overburden the already heavily committed planning agencies.

(8) Leaving independent laboratories out of the planning program will not effect the utilization of testing services since control of utilization is in the hands of physicians, third party carriers and PSROs, not laboratories. Imposing planning requirements on laboratories is therefore not the appropriate vehicle to solve the overutilization problem.

(9) The entities that should be treated uniformly by planning laws are those primary providers supplying direct patient care and not ancillary providers, such as independent laboratories.

The amendment that ACLA seeks would strike the period at line 4 of page 29 and insert in lieu thereof a comma and the following:

except that such term does not include medical equipment which is being acquired for the performance of diagnostic laboratory services by a clinical laboratory which is independent of a physician's office and a hospital and which has been determined under title XVIII of the Social Security Act as meeting the requirements of paragraphs (10) and (11) of section 1861(s) of such Act.

Thus, if this amendment were adopted the definition of major medical equipment purchases subject to certificate of need requirements would read

#### § 1531(7)

For the purposes of sections 1523 and 1527, the term "major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of \$150,000, except that such term does not include medical equipment which is being acquired for the performance of diagnostic clinical laboratory services by a clinical laboratory which is independent of a physician's office and a hospital and which has been determined



'under title XVIII of the Social Security Act as meeting the requirements of paragraphs (10) and (11) of Section 1861(5) of such Act.

ACLA recognizes that strong sentiment exists to apply planning controls to all entities providing health care services. It is, therefore, aware that at first blush some may feel that ACLA's proposal seeks unwarranted special treatment for one segment of the health care delivery system. However, ACLA strongly believes that an objective analysis of the market in which independent laboratories operate combined with a review of the consequences that would flow from imposition of planning controls on independent laboratories support ACLA's conclusion that the injuries that the health care industry will sustain if planning controls are imposed would be far greater than those that might stem from adoption of the exemption ACLA seeks. ACLA has come to this conclusion as a result of the following analysis.

# 1. Independent Laboratories Operate In a Competitive Marketplace.

Independent proprietary laboratories operate in competition with all other facilities offering clinical testing services. The effect of this competition has been to hold down prices and increase the level of services they offer.

The evidence that independent laboratories are already thoroughly regulated by competition, to the advantage of the reimbursement system, comes from the laboratories themselves. Consider the following statistics based on the averaging of several laboratory companies which, like many others, are able to service a variety of regional markets including the Northeast, the Southeast, the Midwest, and the Southwest and the Far West. In each of these market areas, these laboratories report two sharply contrasting developments over the last five years. Since 1973, the prices which they must pay for labor and supplies have soared; meanwhile the prices which they charge for laboratory tests have increased only slightly. For example, the average wages which they must pay a qualified medical technologist has risen from \$3.99 to \$5.94 over the last five years, a gain of 49 percent. Similarly, the average price they pay for a bottle of urinalysis dip sticks has risen 28% during the same period, from \$10.16 to \$12.98. By way of contrast, their average prices for testing services have crept upward only slightly. Their average price for 10 commonly performed laboratory procedures, when billed either directly to the patient or to a third party payor, have increased only 18 cents from \$7.84 in 1973 to \$8.02 in 1977, a five-year price rise of only 2 percent. Because there is less paperwork involved, these laboratories are able to offer lower prices when the charges are billed to the physician at the end of the month. During the five years in question their average charges for these 10 tests, when billed to the physician on a monthly account basis, rose from a low figure of \$4.21 to \$4.89. That gain of 16 percent over five years reduces to an average annual increase of only 3 percent. Whichever price list is examined -- the low

schedule for physician account billing or the somewhat higher schedule for direct patient or third party billing -- the result is the same: These laboratories' charges are rising much less rapidly than its costs.

Many independent laboratories report the same contrasting developments over the last five years: Their costs have been increasing much more rapidly than their prices. A California laboratory reports that its average clerical wage has risen 63% and that its average medical technologist hourly pay rate has gone up 43%. Meanwhile, its prices for 10 common tests have increased only 3% for direct patient and third party billing and no more than 20% for physician monthly account billing. Some independent laboratories have actually decreased their prices during the years since 1973. For example, one laboratory which does business in the Southeast reports that its prices (10 common tests, physician monthly account billing) have declined by 6% during the last five years.

The healthy effect of competition on independent laboratory prices is particularly evident when the slight increases in independent laboratories charges are compared with recent inflation of prices in other sectors of the health care industry. For example, during the two years immediately following the end of the Economic Stabilization Program in April, 1974, Consumer Price Index data shows that physicians' fees rose at an annual rate of 12.5%; hospital service charges rose even more rapidly at an annual rate of 14%. Even prescription drugs, another sector of the health care industry which, like the independent laboratory sector, is regulated by competition, showed a price rise of 7.6% annually. In fact, prices have risen in the independent laboratory sector, if at all, much more slowly than the price of medical care in general. For the last five years for which Consumer Price Index data is available, the cumulative annual increase in the price of all medical care items and services is 37.9%. A comparable price rise for representative independent laboratories in the Southeast, the Midwest and the Far West falls between 12% and 20% for physician monthly account billing and between 1% and 9% for direct patient or third party billing.

Competition does more than confine independent laboratory price rises to rates well below the general inflationary rate in health care. Independent proprietary laboratory prices have also been consistently much lower than the prices charged for the same services by laboratories which are not regulated by competition, that is, laboratories in hospitals and laboratories operating in physicians' offices. Here the rule is clear: independent laboratories generally charge less than half what hospital laboratories and physicians' office laboratories charge for the same service. For example, ACLA members were asked to estimate the cost of a glucose test performed in their market areas by a hospital laboratory during 1977. The estimates ranged from \$8.00 upward, with most estimates targetting a price between \$9.00 and \$10.00. These same

laboratories offered glucose tests to physicians at prices ranging from \$3.75 down to \$2.05.

Proof of the competition afforded by independent laboratories is the emergence and growth of out-patient testing by hospitals, offered at prices substantially lower than in-patients are charged in order to meet the prices charged by independent laboratories. The following chart of the 1976 prices of a Minnesota hospital laboratory, comparing its in-patients charges for six commonly performed tests with its charges to the physician ordering the same tests for his patients (out-patient testing), demonstrates the downward pressure on prices exerted by the independent laboratory market.

Test	In-patient Prices	Out-patient Prices
Glucose	\$ 5.00	\$1.00
T4	\$7.50	\$2.00
Cholesterol	\$5.00	\$1.00
Calcium	\$6.00	\$1.50
Creatinine	\$5.00	\$1.00
Potassium	\$5.00	\$1.00

A similar disparity in price occurs between independent and physicians' office laboratories. For example, ACLA members estimate that a physician's office laboratory in their market areas will charge from \$10.00 to \$25.00 for an electrolyte profile with four electrolytes. The independent laboratories, on the other hand, offer the same procedure to physicians at prices which range from a high of \$7.50 to a low of \$5.00. To be more specific, one independent laboratory estimates that a hospital laboratory will typically charge \$22.50 for an SMA 12/60 in Texas. This same independent laboratory offers the SMA 12/60 to physicians in Texas for \$7.50. Similarly, another independent laboratory estimates that the going rate for a prothrombin time in the Northeast, when performed by a physician's office laboratory, is \$8.00 to \$10.00. The independent laboratory offers a prothrombin time to physicians in the Northeast for \$3.10. The list could be extended indefinitely but the point is clear: independent laboratories, regulated by competition, perform laboratory work at a much lower cost to the reimbursement system than comparable work performed by the non-competition-regulated laboratories in hospitals and physicians' offices.

Another measure of the competitiveness of the independent laboratory industry is the sheer number of independents competing in each local market for laboratory business. It is, of course, a matter of record that there is a large number of independent laboratories competing for business in the United States. The Center for Disease Control itself licenses annually approximately 800 interstate independent laboratories. Most experts place the overall number of independent laboratories much higher, at a total of approximately 7,000. In local markets, the large number of independent laboratories competing for business creates downward pressure on the pricing strategy of each independent. In this connection, it is significant that ACLA member laboratories report that they are not alone in seeking business in their markets. Their estimates of the number of independent laboratories with whom they compete varies from region to region and also with the size of each local market. But there is no mistaking the central point:



independent laboratories see themselves as participants in fully competitive markets in which their own business mistakes will work to the advantage of their competitors.

That independent laboratories compete contrasts strikingly with the realities with which most health providers contend. Many critics of today's health care system attribute some of its deficiencies to the absence of competition. 1/ Government policies should encourage rather than discourage competition. Where competition exists, it should not be destroyed. Failure to adopt ACLA's amendment will result in serious disruption to the competitive aspect of the independent laboratory market. Because the market is competitive, the proposed prior approval requirements are unnecessary.

Proprietary laboratories are in business to make a profit. Business decisions revolve around the question of whether the proposed action will result in a profit. Profit considerations are particularly essential in major medical equipment purchase determinations. No profit making business purchases a piece of expensive equipment unless the decision makers feel reasonably assured that such an expenditure will result in increased profits.

Few businessmen would debate the importance of swift action once a decision is made to purchase a piece of major medical equipment. Requiring a commercial laboratory to apply for authorization to purchase such equipment inevitably retards the process, resulting in lost profits and increased costs. 2/ These delays are inevitable because planning agencies will have many applications to consider. Independent laboratories will doubtless receive minimal attention by these planning agencies as these laboratories comprise a very small segment of the entities subject to planning requirements. ACLA is extremely concerned that, if independent labs are subject to planning, the administrative process will ignore the independent laboratory market in parcelling out certificates of need. Unquestionably, the uncertainty that will be created by not knowing whether authorization will be granted will distort business decisions. Additionally, the requirement that a commercial laboratory acquire authorization prior to purchasing any major medical equipment will doubtless result in disclosure of such information to competitors. None of these ramifications will affect the market positively. In fact, it is foreseeable that competition will decline and prices will increase as a result of these

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1/ The FTC recently held hearings on this problem. During the First Session of the 95th Congress the Senate Subcommittees on Antitrust and Health & Scientific Research, jointly chaired by Senator Kennedy, indicated their interest in the issue of competition in the health care delivery system. HEW Secretary Joseph Califano has also attributed much of the cost escalation in health care to lack of competition.

2/ Presumably the added costs of complying with planning requirements will be passed on to patients in the form of increased prices.

impediments to doing business. (For further discussion of this ramification, see section 2 of this statement).

In determining whether to support ACLA's proposed amendment recognition must be given to the fact that competition in the independent laboratory market has resulted in the two-pronged benefit of braking both escalating prices and major medical equipment purchases. These facts contrast strikingly with what has happened in other areas of the health care system and demonstrate that competition is a more effective and efficient regulator of expansion, equipment purchase decisions and price increases than government regulation.

2. Failure to Exempt Independent Laboratories  
Will Decrease Competition and Lead to  
Concentration Tendencies.

Failure to exempt independent laboratories from planning controls will inevitably lead to increasing concentration within the independent laboratory market, for two reasons. First, the very essence of planning contemplates elimination of a certain number of health care providers through the regulation of capital expenditures. While this control mechanism may be appropriate for cost reimbursed, non-competitive entities to assure that underutilized facilities are not allowed to proliferate, it is not appropriate where competition already effectively regulates expansion and capital expenditure determinations. Thus, if planning mechanisms are imposed on a competitive market, the result will be a decrease in competition since judgments will be made, irrespective of the demands of the marketplace, as to which laboratories will be permitted to purchase major medical equipment and which will not. Those labs that lose in the planning process will also lose in their efforts to compete effectively, and many will undoubtedly go out of business, thereby decreasing the number of competitors.

Second, application of the prior approval laws to independent laboratories will encourage those laboratories that are denied certificates of need or decide not to bother applying for them to acquire laboratories that either already have the equipment or stand a better chance of obtaining the certificate of need. This result could occur because certificates of need are not required for acquisition of existing facilities. Thus, if the planning agency in one state is more favorably disposed to independent laboratories, independent laboratories in that state will become attractive to other laboratories seeking such a favorable planning environment. Since independent laboratories are not geographically limited (see Section 3 of this statement), it would pose no difficulty to acquire a laboratory that has or will be able to obtain the needed equipment and ship specimens to it for testing.

Both of these two factors will decrease competition and will ultimately yield the results that come with any oligopoly - increased prices and decreased services.



3. Independent Laboratories Are Not Geographically Limited And Are Therefore Not Appropriately Subject to Planning.

Significantly, independent laboratories are not limited geographically. Because specimens can be and are drawn and transported to a laboratory many miles away by automobile, post, or airplane, an independent laboratory which is licensed by the Center for Disease Control to accept specimens in interstate commerce has a potential national market. The ability of an independent laboratory to service patients from every state differentiates clinical laboratory providers from most other health care providers. Over a thousand laboratories serve multistate areas. Many more serve two or more of the approximately 200 HSA areas. This fact contrasts dramatically with the service area of almost all of the other entities subject to planning since the potential market of most health care providers is limited to the regions in which they are located.

The importance of this distinction cannot be overemphasized. While it is conceivable that a region could become glutted with health care providers that draw their patients in large part from the community they service, such is not the case with independent laboratories and particularly those labs licensed under the Clinical Laboratories Improvement Act of 1967 that by definition are involved in interstate business. Two independent laboratories standing side by side often serve very different constituencies. Therefore, once there are adequate laboratory services in a particular community, each laboratory can attract specimens from other communities by offering one or all of the following: (1) lower prices; (2) better quality; (3) quicker processing; (4) more sophisticated capabilities; or (5) a service which formerly did not exist.

Planning is predicated upon the notion that with a requirement of authorization for capital expansion based on regional need for additional health services, the proliferation of unused facilities will abate. Since independent laboratories can and do obtain business from beyond the region and state in which they are located, the rationale of the program does not apply to independent proprietary laboratories.

ACLA recognizes that the drafters of H.R. 10460 have attempted to solve the problems created by application of prior approval requirement to facilities serving populations from outside the health service area by authorizing planning agencies to coordinate their efforts and to review the need for capital expenditures for all services provided within the area. ACLA also recognizes that these modifications have been made to accommodate such entities as the Mayo Clinic. There is a distinct difference between evaluating the needs of a Mayo Clinic and the needs of an independent laboratory. First, a predictable forecast can be made as to how many beds Mayo Clinic will need in the future since to be treated by the Mayo Clinic, patients must go to Rochester, Minnesota. Patients whose specimens are tested by out-of-state laboratories do not travel to that laboratory for specimen collection. Thus, predictions as to need cannot be made as to how many specimens will come from outside the health service area in which the laboratory

is located. For example, the planning agency considering the application for certification will not have sufficient information to determine what other planning agencies it should consult for need determinations. Second, a far greater number of independent laboratories serve large interstate populations than hospitals. Since over 1000 laboratories presently operate interstate, vast administrative problems would be created by any attempt to obtain a multiregion, multistate decision as to whether a certificate of need should be issued for a laboratory's proposed purchase of an expensive piece of equipment. These administrative problems would be so profound that ACLA believes that imposition of a planning program on independent interstate laboratories would be unworkable, possibly unenforceable and clearly inapplicable to the realities of the laboratory market. Two examples of situations that could occur demonstrate the problems that would attend imposition of planning controls on the purchases of equipment by independent, interstate laboratories.

A laboratory in state X operates interstate. Its officers decide that there is an opportunity to obtain business in states A, B, C and D and that acquisition of such business will necessitate acquisition of a new piece of equipment. If ACLA's amendment is not adopted, the laboratory would have to apply to the relevant agencies in the state in which it is located for approval to purchase the equipment. How would those agencies determine whether to issue the certificate? Would they consult with all the planning agencies in states A, B, C and D? Would the planning agencies in states A, B, C and D be willing to help states make such a decision when they realize that issuance of such a certificate might deprive each of their states of needed revenues? Would not such a process take time and use up scarce resources? If the planning agencies in state Y failed to consult the planning agencies in states A, B, C and D, would not state Y's failure constitute a burden on interstate commerce?

The second troublesome fact situation which would arise were the major medical equipment purchases of interstate independent laboratories subjected to prior approval requirements is as follows: A laboratory in state A decides that there is a business opportunity in state B. State A grants the laboratory the certificate of need for expansion for which it applies. The laboratory expands, and successfully solicits business in state B. Laboratories in state B seeing a missed

business opportunity apply to state B for a certificate of need authorizing equipment purchases. The state B agencies have two choices: (1) they can grant the necessary authorization, realizing that by the time the state B labs are geared up to compete with the state A lab, there may no longer be any untapped business; or (2) they can deny the application stating that there is no longer any need for additional laboratory services within state B. By taking the second course, the agencies must realize that they are denying the state another source of revenue. Additionally, it is politically unrealistic to assume that in the second example state B would deny the application since to do so would place state B labs at a competitive disadvantage with its out of state competitors.

A list of such examples could be endless. ACLA does therefore not believe that the coordination that H.R. 10460 envisions will prevent these situations. In fact, ACLA suggests that these two hypothetical situations would surely materialize should the major medical equipment purchases of independent laboratories be subjected to prior approval requirements. Moreover, this situation could be further complicated by the fact that different states might apply dissimilar standards in dealing both with this problem.

Additionally subjecting independent laboratory equipment purchases to the prior approval requirements will play havoc with the planning agencies, as discussed at Section 7 below, particularly where the applying lab is engaged in interstate business.

#### 4. Independent Laboratories Provide Ancillary Rather Than Primary Services.

Independent laboratories are ancillary rather than primary providers of service. In this sense they function more like pharmacies than hospitals since these laboratories do not provide direct patient care and can only perform tests at the initiation of a physician. Thus, it is the physician who controls the ordering and utilization of testing services and not the laboratory, just as it is the physician who controls the purchase of prescription drugs and not the pharmacy. To be sure, certain unethical laboratories have used this fact to justify the payment of rebates and kickbacks to increase business. 3/ These practices have tarnished the entire independent laboratory market, and ACLA believes they must be stopped. The recent enactment of H.R. 3 should put an end

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3/. It is interesting to note that these illegal arrangements demonstrate that the market is indeed competitive. Elimination of these practices can be obtained without elimination of the competition that may have spurned them.

to these practices. Subjecting independent laboratories to planning requirements, however, is not the answer to the fraud problem. ACLA believes that since pharmacies and laboratories provide similar support services, they should be treated equivalently by the planning laws.

The concept of prior approval is attractive. The proposition that all segments of the health care industry should be subject to the same planning requirements is also attractive. The issue boils down to the definition of which segments are referred to in the statement that all segments should be equally treated. Does "all segments" include pharmacies? Does it include medical device manufacturers? Does it include pharmaceutical manufacturers? In other words does "all segments" include those secondary parts of the industry that provide support to the primary segments and that are only utilized when ordered by the primary segments? ACLA firmly believes that controls should be levied on the entity determining utilization and that the secondary segments should be allowed to compete freely so that the primary segments will have the full benefits of competition when utilizing the secondary segments.

ACLA would define primary providers as those that supply direct patient care. Regulation of primary providers is in order because of the expense that has resulted from the proliferation of unused facilities. Additionally, this segment of the health care industry lends itself to predictions concerning need. Thus, determinations can rationally be made about the percentage of the population which will require hospitalization, institutionalization or direct attention to combat disease or injury. The overall capacity of such direct patient care facilities and providers can accordingly be geared to need.

Unlike primary care providers, independent laboratories do not supply direct patient care. They provide services which aid the physician in diagnosis and treatment of disease. In addition, one of the most important and fastest growing uses of laboratory testing is for health maintenance and disease prevention. In contrast with the services of primary providers, there are no ascertainable limits on testing services by independent laboratories. For example, a rising number of industrial companies are initiating employee health programs that use low cost laboratory test screens as a tool to detect incipient conditions that, if undiscovered, and allowed to worsen, could lead to high cost hospitalization. Thus, the determination of how many independent laboratories should be permitted to exist within a defined region would be difficult at best.

##### 5. Independent Laboratories Are Charge Reimbursed, Not Cost Reimbursed.

Primary institutions are particularly suited to health planning because they are cost reimbursed. Thus, regardless of expenditures, they are assured of ultimate payment equal to expenditures. As a result of this fact, there has been no incentive to abstain from overbuilding or overpurchasing. This situation contrasts markedly with the manner in which independent



laboratories establish prices, collect fees, obtain reimbursement and finance purchases of major medical equipment.

At the outset, independent laboratories determine prices in the context of competitive pressures and reimbursement policies that tend to place a lid on inflation. Reimbursement under Part B of Medicare is based on reasonable charges which are computed by examining the laboratory's actual and customary charges, and the prevailing charges in the locality. 42 U.S.C. § 1395u(b)(3). Thus, all charges are measured against each other and affect the amount of reimbursement that a lab will receive. This mechanism is markedly different from the rules applicable to such cost reimbursed entities as hospitals. Independent laboratories are not reimbursed for their costs should they prove to be higher than their income. For this reason, independent laboratories are very careful before deciding to invest in major medical equipment. Knowledge that losses will occur if unwise expenditures are made operates as a more effective curtailment on growth than any regulatory scheme could. Independent laboratories purchase major medical equipment at risk; they finance this risk out of profits or private capital, not federal funds. As a result, purchases that turn out to be mistakes do not affect the public purse. However, as a general rule, equipment purchases do not turn out to be mistakes as the decision to make the purchase has been carefully weighed. In fact, the purchase of the equipment typically results in economies of scale that tend to lower unit price.

#### 6. The ACLA Amendment Would Authorize Exemption Only to Quality Laboratories.

As the Subcommittee on Health and the Environment well knows, some clinical laboratories are substandard. Such laboratories should not be allowed to purchase major medical equipment without prior approval. ACLA's proposal amendment would solve this problem by limiting the exemption to laboratories certified as in compliance with the Medicare Conditions for Coverage of Services of Independent Laboratories, set out at 20 C.F.R. § 405.1310. These regulations embrace those elements necessary to assure quality performance. Thus, uncertified, substandard laboratories would be subject to the prior approval requirements.

#### 7. Subjecting Independent Laboratory Purchases to Prior Approval Will Overburden Health Planning Agencies.

Planning agencies, already heavily committed, will be given additional responsibilities by H.R. 10460. Adding independent laboratory review to their duties will undermine their abilities to carry out and perform their other functions. In addition, planning agencies will be faced with the knotty problem of how to deal with interstate laboratories since many central laboratory locations serve as many as twenty or more states. While H.R. 10460 authorizes cooperation between planning agencies, the bill does not meet the problems which will be created by inclusion of independent laboratories. It provides



no guidance as to how a planning agency should determine whether to issue a certificate of need for the purchase of major medical equipment where the applying laboratory proposes to test the specimens of patients from many states. Is the planning agency to consider the out-of-state services that the applying lab provides in weighing whether to issue the certificate of need? If so, how will the planning agency determine the needs in the other states? Is the planning agency required to consult with the planning agencies of the states from which specimens might be transported? Will the decision-making process amount to an unconstitutional burden on interstate commerce? These questions are only a few of the many that will confront the planning agencies. At a time when planning agencies are already struggling with the responsibilities they must assume, it seems unwise to burden them with these particularly difficult issues.

8. Adoption of the ACLA Amendment Is Not  
Likely To Result In Overutilization of  
Independent Laboratory Services.

It has been suggested that if independent laboratories are not subject to prior approval requirements, these laboratories will purchase major medical equipment without controls, and that such purchases will encourage overutilization.

The utilization of laboratory tests is a matter that is entirely in the hands of the physician. No laboratory may lawfully perform a test without an order from a physician. Thus, independent laboratories cannot boost volume to secure a return on investment in major medical equipment. 4/ Independent laboratories therefore carefully measure the market before they purchase new equipment. When they decide to purchase such equipment they do so in order to service their existing markets, operate more efficiently or expand to a market they know they can obtain. Independent labs, like any business, cannot safely increase capacity without prospects of business in hand.

While the offering of kickbacks and rebates by a small segment of the independent lab market may have lead to some overutilization, recent enactment of H.R. 3 should cure this problem.

The answer to controlling overutilization, a concept which implies the provision of services that are not medically

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4/ This situation is in striking contrast with purchases of major medical equipment made by practicing physicians who are in a position to assure a return on investment by ordering procedures for their patients that require utilization of that particular equipment. It should also be noted that ACLA's language would only apply to purchases of equipment for performance of laboratory tests. Thus, purchases of equipment such as CT scanners would still require the appropriate certificate as CT scanners do not perform laboratory tests.

necessary, lies with: the physician, the public and private third party carrier. The PSRO program, tied to denial of reimbursement, should be used as the mechanism to control the ordering patterns of physicians since the statutory mandate directs PSROs to deal with overutilization. Third party carriers should more actively enforce their policies of disallowing reimbursement where the testing services are not medically necessary. We note that Medicare already disallows such reimbursement. Blue Shield also has begun to scrutinize claims for laboratory testing services more carefully in an effort to discourage overutilization.

Planning is not the proper program to deal with the overutilization problem. While the planning mechanism may be an effective tool in controlling the proliferation of underutilized facilities, it was never intended to cure the overutilization problem. In addition, ACLA believes that planning cannot solve the problems of laboratory utilization. What planning will mean if it is applied to independent clinical laboratories is a diminution of quality and increased cost as those laboratories that are unable to obtain approval to purchase equipment will have two options: (1) they will be forced to perform many tests manually which, in certain instances, produces less accurate results; or (2) they will be forced to lengthen turn around time resulting in the physician's delayed receipt of test results. Neither of these results is desirable. Both of these results will produce added costs that will be passed on to the patient or third party carrier.

9. All Entities Supplying Primary Health  
Care Services Should Be Treated Uniformly  
By the Planning Laws.

It is a superficially appealing proposition to suggest that all entities supplying health care services should be treated uniformly by the planning laws. In fact, as noted at Section 4 of this Statement, all primary providers of health care services should be subject to uniform planning laws. There are certain types of suppliers, however, that as a result of the environment in which they operate cannot be classified in the same fashion as such primary providers and are not appropriately subject to planning laws. Independent laboratories are unique, for the reasons discussed above. Thus, what is needed is a redefinition of the scope of the planning laws. With such a redefinition uniform treatment could be obtained, along with the recognition that certain ancillary providers do not belong within the laws' scope.

## CONCLUSION

The competition between independent laboratories is fierce; it regulates expansion, prices, and services. It regulates these factors efficiently and without government intervention. ACLA firmly believes that this Subcommittee, as well as those other legislative and administrative entities involved in deciding how health services are delivered, should encourage healthy

competition as it is found in the independent laboratory market. Until evidence is presented that planning controls would be a more effective regulator than competition, independent laboratories should be excluded from planning controls. Where a system is working well, the burden should be on those who seek to change it to prove that such change will improve it. As a case has not yet been made as to the wisdom of imposing planning requirements on independent laboratories, such controls should not be imposed.

Mr. CARTER. How much does your laboratory charge for a VDRL?

Mr. JOHNSON. About \$2.50. We don't have consistent national pricing, but that is the average price.

Mr. CARTER. Is that required before marriage down in Florida as it is in some States?

Mr. JOHNSON. It is required in most States before marriage.

Mr. CARTER. What do you charge for BUN's?

Mr. JOHNSON. BUN, about \$3.50 to \$4.

Mr. CARTER. Blood Sugar?

Mr. JOHNSON. \$2.50 to \$3.

Mr. CARTER. And blood sugar tolerance test?

Mr. JOHNSON. Probably, our tolerance test would be \$6 to \$7.

Mr. CARTER. CBC?

Mr. JOHNSON. About \$4, maybe \$4.50, and urinalysis \$2, \$2.25, \$2.50.

Mr. CARTER. Do you do radiological work?

Mr. JOHNSON. Very few of our laboratories do. We do not attempt to do X-rays.

Mr. CARTER. What about tissue sections?

Mr. JOHNSON. Yes; in most of our laboratories we do anatomical work.

Mr. CARTER. What do you charge for that?

Mr. JOHNSON. We do it under the direction of a pathologist, and tissue fees vary around the country, too, according to the practice there, but I would say the average charge to a doctor for a tissue is \$10 to \$14.

Mr. CARTER. Your list of charges are quite reasonable.

Mr. JOHNSON. And they are all published.

Mr. CARTER. Thank you very kindly.

Mr. ROGERS. Thank you very much for your testimony and I think the committee would like to ask your cooperation in giving some ideas—where you say you would work with the committee and the administration to find ways to minimize health care cost increases in the laboratory area. We would like to be in touch with you and we will ask your cooperation, to have the staff be in touch and get suggestions.

Mr. JOHNSON. Chairman Rogers, I believe you were out when I mentioned on our full text presentation, page 2, the middle of the page, we suggest language to change the present H.R. 10460.

Mr. HALPER. May I also point out that it has been suggested that if independent clinical laboratories were exempted they might go into the CAT Scan business. ACLA's amendment at page 2 of its statement very carefully limits the exemption to the purchase of clinical laboratory equipment for clinical laboratory services. If any laboratory were to go into the CAT Scan business, it would have to comply fully with all planning requirements. I would add, however, that we know of no independent laboratories entering into the CAT Scan business.

Mr. ROGERS. Thank you for your patience, and this concludes the meeting. The committee is adjourned.

[The following statements and letters were received for the record.]



## AMERICAN ACADEMY OF PEDIATRICS

Testimony before the

Interstate and Foreign Commerce Committee  
Subcommittee on Public Health and EnvironmentAmendments to the Health Planning Act  
H.R. 10460

The American Academy of Pediatrics, an international medical association and children's advocate representing nearly 20,000 pediatricians dedicated to the care of infants, children and adolescents, wishes to submit the following written testimony for inclusion in the record of hearings held on the Health Planning and Resources Development Amendments of 1978 (H.R. 10460).

The American Academy of Pediatrics is not a stranger to health planning. In furtherance of one of its Constitutional objectives that it shall "function as an effective advocate for children in all matters pertaining to child health and child health care," the Academy is responding to the request in P.L. 93-641 for provider participation in the development of Health Systems Plans, Annual Implementation Plans and State Health Plans. Years before congressional adoption of P.L. 93-641, the Academy officially endorsed the need for proper planning for the special health needs of children. With the adoption of P.L. 93-641, the Academy renewed the endorsement by asking its Chapters to support the concept of health planning. Our policy and cooperation were demonstrated by initiating a program that involves each of our Chapters in the development of a plan for child health services. These activities have established the Academy as a responsible, national professional organization that has accepted involvement with planning child health care as a responsibility of leadership.

The Academy offers the following views and recommendations as a friendly, constructive critic whose members have extensive experience with the Health Planning Act and hope that that nationwide experience will be reflected in these and future amendments to the Act.

Our efforts in this area were recognized in a December 1977 letter from Harry P. Cain, II Director, Bureau of Health Planning and Resources Development, to all Health Systems Agencies, State Health Planning and Development Agencies and Statewide Health Coordinating Councils. In his letter, Dr. Cain cited the Academy's "interest in plan development activities" and recommended local Academy Chapters throughout the country as possible participants in future child health planning activities. He also listed two Academy publications, "A Handbook on Child Health Planning for AAP Chapters" and "A Sample Child Health Plan for AAP Chapters," as being of possible use to health planners. The Academy welcomes Dr. Cain's recognizing that local Academy Chapters, with their knowledge and expertise in problems affecting local areas, can provide valuable planning assistance. The Academy has appropriate experience, expertise and resources and seeks to contribute to future health planning.

It is the position of the American Academy of Pediatrics that there is a need for national goals for child health and a need for methods for establishing those goals. Accordingly, the Academy supports the stated purpose of the Health Planning Act. But we believe the Act needs major redesigning with respect to the means it employs to achieve its goals, and that special recognition of the needs of children is called for in any national health planning document.

We would recommend that such recognition take the form of an amendment to Section 1502 of the Health Planning Act, "National Health Priorities," adding as priority number 11:

"(11) The development of a comprehensive plan for the achievement of equal access to quality health care at a reasonable cost for all children, from conception to young adulthood."

The Academy wholeheartedly agrees with the interpretation of the Act as put forth in the Federal Register January 20: "... it is the clear intent of the Health Planning Act that health planning be conducted at State and local levels." It is our firm belief, however, that in spite of assurances of local control of health planning, substantive initiatives in that direction have not been forthcoming. We would submit that the public uproar which greeted Secretary Califano's promulgation of health planning guidelines last September suggests less than close coordination with local planning officials and needs. It is the Academy's position that the Secretary should identify national goals and establish state and local entities to accomplish those goals -- but not set quantitative standards or mandate compliance. The Secretarial function should be strictly advisory. The Secretary's authority over grants and loans under the Act runs counter to local-level decision making and is tantamount to his having the power to close hospitals and other health facilities.

The Academy believes the federal government's role in health planning should be one of cooperating with professional and consumer groups to identify and recognize national health priorities and to provide incentives for improving health services.

The Academy believes the role of state and community governments is one of cooperating with public and private sectors in determining the health status of an area, in identifying health services, in determining accessibility and utilization of services, in determining deficits in health services and in creating community and regional goals.

The Academy believes the governmental process prescribed by P.L. 93-641 -- federal control of planning, resource development, regulation (standard setting), review and rate setting -- will be inflexible, expensive, unresponsive and unsuccessful. The Academy believes this nation to be so large and so diverse as to make fixed federal controls set in place by this law impractical, improper and unworkable. Therefore, the Academy would support a decentralized version of the law in which states would be responsible for providing certification and assurance of compliance with essential regulations, as developed by the public and private sectors.

The Academy especially commends two of the proposed amendments - requiring closer coordination between HSA's, state agencies and entities reviewing rates and budgets of health care facilities, and expanding the role of local officials in health planning. But at the same time the Academy questions the continuing exclusion of appropriate numbers of physicians from the health planning process.

The Academy does not contest the concept stated in the foreword to the Act, under Section 2:

Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

The Academy, however, finds it difficult to understand how subparagraph (b), (3), (c) of Section 1512, which specifies the composition of HSA membership, reflects this policy. HSA governing body and executive committee members are not selected on the basis of training or experience but on their social representativeness. This method of determining the composition of HSA planning bodies assures that consumer members, who will be in the majority, may be informed about social and community problems but not that they will be informed about the technical issues and complex problems of providing health care.

There is a need for more physicians and major health providers "to play an active role in developing health policy at all levels" and to serve on HSA planning bodies, but the law defining composition of those bodies allows few physicians to serve. (We would again point to the Academy's previously mentioned participation in health planning activities as evidence of the contribution physicians can make.) It is, therefore, not surprising that the medical profession and other major health providers feel that the Health Planning Act has been designed to exclude them. This exclusion creates distrust and lack of confidence. These are the same problems that plagued the Comprehensive Health Planning Act. Many providers who were involved with councils created by that Act believe that one, if not the major, cause for the Act's limited success was the make-up of the councils. The councils were composed of consumers who were interested and often dedicated, and many of them were experienced in serving on public committees; but there just were not enough council and committee members knowledgeable about health matters to handle the many detailed technical questions and complex issues related to the provision of health care.

The Academy appreciates the obvious concern for avoiding provider domination of health-planning bodies, but we believe that concern has been more than adequately addressed. In fact, providers, and more specifically physicians, are outnumbered on health planning bodies to the extent that they often have no impact on decision making. In no way are providers dominating the planning process. In view of the widespread sentiment for greater consumer representation on planning bodies, the Academy would suggest not that the provider category be increased but that one-half the membership of any provider category consist of physicians.

Those whose daily lives have been most affected by the Health Planning Act are well aware that health plans developed at state and local levels vary greatly in their value and applicability. Some of these plans are workable, firststage documents, but others appear to have been prepared in a vacuum rather than a health-care environment. The Academy strongly believes that input by physicians at all stages of the health planning process should be encouraged and could do much to remedy current shortcomings if taken advantage of.

In this regard we offer the following amendments to the Act:

Sec. 1512, (b)(3)(b) "Responsibilities," add (ix) "shall be responsible for establishing working relationships with physicians' organizations (and other health providers) to obtain expert advice in performing the functions listed in items (i) through (vii) above."

Sec. 1513, (c)(1)(F) after "Federal health programs") insert "work cooperatively with physicians' organizations."

Sec. 1513, (c)(1) after "public and private entities" insert "and medical organizations."

Sec. 1513, (d) change (4) to (5) and insert as (4), "physicians' organizations and other health providers so as to obtain expert advice in performing the functions listed in (b), (1), (A) through (F) and to insure understanding and coordination in the implementation of the HSP."

The Academy opposes amendments that would extend certificate of need requirements to physicians' offices for expenditures exceeding \$150,000. The certificate of need concept is not new, but its value has not been proved, and many respected health planners continue to have major reservations about the concept's effectiveness. The original Act's making this function a responsibility of the State Agency seemed premature to the Academy, and its extension of the concept to include physicians' offices compounds the problem. We oppose the extension of certificate of need to physicians' offices as further government intrusion which erodes the individual's right to decide where and how he will practice medicine.

The Academy also entertains serious doubt as to the feasibility of appropriateness review. A review of all institutional health services in a service area is staggering in size and complexity. Judging the appropriateness of such services and recommending projects for modernization, construction and conversion of medical facilities would seem nearly impossible. The possible disruptive effect on our health-care system of judgmental errors in appropriateness review should not be ignored.

Finally, the Academy believes that health planning, as is true of all forms of community planning, is in an embryonic state and that it is unrealistic to require HSA's to develop detailed health plans at this time. The Academy believes that information concerning health status, the quality and availability of health services and utilization of health services is both complex and frequently inaccurate. Such information should be used only to create general guidelines for planning. The use of such information to create detailed plans for changes in health services would be unwise at best and could be disastrous.



Recent experiences with rigid guidelines promulgated by Secretary Califano serve to point up the inapplicability of national, quantitative health planning guidelines to each and every locality. Such guidelines should be advisory in nature and as flexible as possible so as to accommodate diverse health needs of different areas of the country. Academy publications cited by health planning officials and mentioned at the outset of this testimony offer alternatives to numerical standards and allow physicians to lend their expertise to local health-planning efforts. The Academy sincerely believes that such an approach is the only viable application of the Health Planning Act and its amendments to our health care system.



## *American Academy of Pediatrics*

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DEPARTMENT OF GOVERNMENT LIAISON  
ELIZABETH J. NOYES, CHIEF

### ISSUE PAPER: GENETICS

#### What's At Issue

The expiration of the "National Sickle Cell Anemia, Cooley's Anemia, Tay Sachs, and Genetic Diseases Act," Title IV of P.L. 94-278. Issues which must be addressed in the development of the new legislation include: regional problems, informed consent, pilot studies, quality control, standards, liability and the role of advisory boards.

#### Why Important

It is the intent of this legislation to establish a national program to provide for basic and applied research, research training, testing, counseling and information and education programs with respect to genetic diseases. While its intent is laudable, dollar restrictions placed on the various programs under this law focus most of the attention on sickle cell anemia and Cooley's anemia. Funding levels, not appropriated until December, 1977, were at such a low level that the implementation of the programs under law are in jeopardy. With the expiration of this law in 1978, attention must be directed toward the development of guidelines concerning the implementation of the present law and look toward the needs of a genetic services program which is truly comprehensive in nature.

#### Major Proposals

S. 2474 (Kennedy, D-Mass.), "Health Services Extension Act," provides for a one-year extension of the Genetic Diseases Act. There is a good possibility that Senator Kennedy will include the Genetics Diseases Act as part of a "prevention package" to be introduced next month.

H.R. 10443 (Rogers, D-Fla.), "Health Services Amendments," provides for a one-year extension of the Genetic Diseases Act.

#### Administration Position

A Public Health Service Genetic Coordinating Committee has been established within HEW to develop information in regard to the renewal of this Act. Issue Papers are in the process of being developed for the Administration.

HEW Assistant Secretary for Health Julius Richmond has opposed one-year extensions and said that the Department would submit a consolidation proposal on the various health service programs.

AAP Position

The Academy's Task Force on Genetic Screening in its 1976 statement clearly stated a number of recommendations which should be considered in the implementation of the current National Genetic Diseases Act and supported the National Academy of Science recommendations in this regard. These recommendations include:

1. The objectives of genetic screening,
2. Criteria for screening tests,
3. Retrieval of the person with a positive test,
4. Confirmation of positive screening tests,
5. Follow-up counseling and treatment, and
6. The possible development of a Commission for screening practices.

Action Timetable

The Senate has scheduled hearings on February 1 and March 1 for all expiring health legislation. Renewal of genetic legislation will be discussed at that time. House hearings have been set for February 21-24 and March 1-3.

STATEMENT OF THE  
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO  
TO  
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
OF THE  
HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE  
ON  
H.R.10460 "THE HEALTH PLANNING AND RESOURCE DEVELOPMENT AMENDMENTS OF 1978"  
(INCLUDING TITLES II AND III OF H.R.9717)  
February 17, 1978

The American Federation of State, County and Municipal Employees, AFL-CIO represents more than 750,000 members, over 150,000 of whom work in public general hospitals throughout the country.

The Health Planning Amendments of 1978 focus on three major problems in our national health planning system: excess hospital beds, under-funded public general hospitals and consumer participation in health systems agencies.

Our union has consistently supported strong federal action to stop excess hospital construction. In 1975, we petitioned HEW for a moratorium on hospital building. Characteristically, the Ford Administration took no action on the petition. But when the present Administration proposed limits on capital expenditures as part of its hospital cost containment legislation, we supported the effort.



H.R.10460's approach (incorporating portions of Title II and III of the Subcommittee's Amendment to H.R. 9717) to our national excess of 100,000 hospital beds is to create both requirements and incentives to close beds for the major interests affected, namely hospital administrators, owners and investors. To completely close down a hospital, the bill offers both debt and incentive payments. To close part of a hospital, the bill offers incentive payments alone. And to promote ambulatory home health and long-term care centers, the bill offers substantial conversion payments to hospitals. In effect, hospital administrators and investors would lose nothing by closing or converting a hospital. But what about hospital employees?

As drafted, the amendments would allow a hospital seeking to completely or partially close its beds to apply for an incentive payment to cover the costs of planning, construction, equipment acquisition, merger, service delivery, as well as termination pay and retraining costs for employees affected by the closure. While the hospital would have to state in its application how it intends to spend its incentive payment, as well as describe the impact of the closure on both the community it serves and its employees, the hospital itself would receive and spend the entire payment.

Hospital employees would have to compete along with all of the other closure priorities for a share of their hospital's incentive payment. As a result, this Committee's laudable intent -- to protect hospital workers -- would depend entirely upon the size of the incentive payment and the generosity of a hospital administrator.

Presumably, of course, HEW would monitor each hospital receiving an incentive payment. But HEW's record in protecting employees affected by institutional closures has been dismal, indeed. Charged with protecting mental health and mental retardation employees (The Health Revenue Sharing Amendments of 1975, PL 94-63, amending §14(d)(2)(D)(i)(II) of the Public Health Service Act; The Developmentally Disabled Assistance and Bill of Rights Act of 1975, PL 94-103, amending §134(a)(29) of the Developmental Disabilities Services and Facilities Construction Act), HEW has failed even to issue the required regulations, let alone monitor the 50 states receiving funds. Clearly, HEW would be hard pressed to monitor all of the hospitals receiving funds under these health planning amendments. (There are, of course, over 7,000 possible applicants for incentive payments).

The Secretary of Labor, however, has also been charged by Congress with protecting employees affected by discontinuance of services and other changes in employment. (Urban Mass Transportation Act of 1964, 49 U.S.C. §1609(c) and the Rail Passenger Service Act of 1970, 49 U.S.C. §565). In contrast to HEW's failures, the Labor Department's record has been very good. It's primary mission, of course, is to protect the interests of employees. We therefore urge this Committee to require that the Secretary of Labor review and approve the employee protections provisions of each incentive payment before any payment may be made to a hospital.

Not only is the Secretary of Labor's record on employee protections superior to HEW's, but Labor has been charged by the Congress to promote and expand employment interests. Unless adequately monitored and enforced, incentive payments to hospitals to close down beds will inevitably lead to more unemployment. Neither hospitals, nor HEW is a natural advocate of employment -- particularly employment of low-wage, semi-skilled labor. The health planning legislation, therefore, must assure hospital workers that their interests will be virgorously protected by a skilled and effective advocate of employment -- the Department of Labor.

We have proposed specific language for the health planning amendments to properly reflect the need for comprehensive employee protections. (Amendments are attached on page 7).

#### PUBLIC GENERAL HOSPITALS

H.R.10460 properly recognizes the special needs of public general hospitals. These often financially-strapped facilities are the last resort for poor people's health care. Drug addicts, alcoholics, and uninsured patients are routinely referred by private hospitals to public general hospitals. Legally, in almost all jurisdictions, public hospitals must treat any patient who needs care.

Inadequate funding and administrative intransigence have deprived public general hospitals of much needed funding for life-safety and licensure compliance. Section 1625 of the Health Planning Act has never provided more than \$11 million annually for America's over 1700 public general hospitals. At the same time, the Joint Commission on Accreditation of Hospitals has increased disaccreditations and provisional accreditations of public general hospitals. With constrained city and county budgets, public hospitals have been forced to severely curtail services, staff, and purchases of needed new equipment.

The proposed increase in funding for public general hospitals is obviously essential to their survival. The increase, however, would barely cover the funds needed to assist the 1977 applicants who applied knowing that HEW had only allocated \$11 million for assistance. The proposed FY 1979 authorization of \$75 million would barely cover the costs of renovating Philadelphia's former public hospital, Philadelphia General. We recommend a substantial increase in the authorization to \$200 million for FY 1979, \$250 million for FY 1980 and \$300 million for FY 1981.

#### CONSUMER PARTICIPATION

Better consumer participation in Health Systems Agencies is critical to an effective control over run-away provider abuse of our health care system. H.R.10460 would make it easier for consumers to gain positions on Health Systems Agencies. We are particularly



encouraged by the amendment to specifically recognize unions as major purchasers of health care. Training for consumers is also vital to their effective participation in the HSA decision-making process.

Yet staff assistance, as recommended by the Consumer Coalition for Health, is also necessary if consumers are to adequately present their views in Health Systems Agency discussions. Independent staff consultants would provide consumers with an objective analysis of HSA activities just as provider representatives have their own staff assistants to independently analyze HSA actions from a provider perspective.

To summarize, the American Federation of State, County and Municipal Employees supports the principal objectives of H.R.10460 to reduce the supply of excess hospital beds, assist public general hospitals and expand consumer participation in health systems incentive payments under the Act. Funding should be expanded for public general hospitals. And special funding should provide consumers on health systems agencies with their own independent consultants.

Proposed Amendments to Title III of H.R. 9717

1. The Secretary of Labor shall prescribe fair and equitable arrangements to protect the interests of employees affected by any debt or incentive payment made by HEW pursuant to such protections shall include, but not be limited to

- a) preservation of rights, privileges and benefits (including continuation of pension rights and benefits) under existing collective bargaining agreements or otherwise;
- b) the continuation of collective bargaining rights;
- c) the protection of individual employees against a worsening of their positions with respect to their employment;
- d) assurances of employment to employees of merged hospitals and priority of re-employment of employees terminated or laid off in the event of whole or partial closure of a hospital or conversion of a hospital to other than inpatient care;
- e) adequate severance pay;
- f) paid training or retraining programs.

Such provisions shall include arrangements protecting individual employees against a worsening of their positions with respect to their employment.

The Secretary of Labor shall specify the terms and conditions of the protective arrangements for any debt, incentive or conversion payment made pursuant to this Act.

2. Any hospital applying for funds under Section 303 must
  - a) provide evidence that prior to its application for assistance it has notified and consulted with its employees concerning its planned discontinuance or conversion of beds; and
  - b) provide a detailed impact statement concerning the effect of the closure or discontinuance upon its employees.
3. Direct notice of the availability of employee protections payments shall be given to the employees' collective bargaining representative, if any, and to each affected employee.
4. A program of additional incentive payments shall be made available to any hospital in the same area as a hospital discontinuing or converting its services. Such payments shall be used to assist the applicant hospital in hiring employees displaced by a hospital discontinuing services.

The program shall be administered by the Secretary of HEW and approved by the Secretary of Labor pursuant to the DOL employee protections provisions described above. Strict attrition provisions shall prevent any excess staffing at any hospital.

AMERICAN NURSES' ASSOCIATION

Statement On

H.R. 10460

Health Planning and Resources Development Amendments of 1978

February 23, 1978

Submitted To

Subcommittee on Health

Interstate and Foreign Commerce Committee

U. S. House of Representatives



The American Nurses' Association is pleased to have this opportunity to submit comments on H.R. 10460, "Health Planning and Resources Development Amendments of 1978."

In general, we agree with the intent of the amendments and the changes which will occur as a result of these changes in the Act. The American Nurses' Association has previously publicly stated strong support for the health planning efforts designed to ensure an adequate supply and distribution of health care services. We have been disappointed by the slow development and implementation of Public Law 93-641, "National Health Planning and Resources Development Act of 1974." Therefore, we concur with the decision to extend the current law with few revisions. The Association would support a three-year extension, rather than one year as provided in the amendments, as it would give a longer period of time to implement and evaluate the impact of the health planning activities which are just now getting underway. So few of the Health Systems Agencies have received full-designation and are in full operation that it seems advisable to provide a longer period of operation before more changes are made.

Sec. 201 (d) Revision and Reporting on National Guidelines for Health Planning

The national guidelines for health planning have not been completed. Yet, the new amendments would require an annual review of the standards and goals by the Secretary for the purpose of making revisions. Unless

the process of issuing the first and basic set of guidelines can be accelerated, yearly review appears overly optimistic. However, we do agree that public dissemination of information about the success or lack of success in meeting the set goals would be helpful.

Changes recommended in Section 1501 would also make more specific the Secretary's responsibility in collecting and reporting data related to "personnel, facilities, and other resources needed to meet such standards and goals." Additional changes are recommended for Section 1513 which specify the health systems agency responsibility for assembling and reporting data to the Secretary. We would urge that careful thought be given to the data collection systems already in place through the National Center for Health Statistics or other national data collection programs. The establishment of a duplicative collection system through the Health Systems Agencies and State health planning and development agencies should be avoided.

#### Sec. 202 National Health Priorities

ANA supports consolidation or elimination of unneeded facilities. We would hope, however, that facilities would not be closed without provision of alternative health care services and that staff employed in such settings would have adequate time to plan career changes.

#### Sec. 208(a) Local Financial Support of Health Systems Agencies

We question the change which would allow a health care insurer to make a private contribution to an HSA. This could permit some pressure on the agency, which would not be in the best interest of the total

population served by the HSA. We believe funding for planning should come from public sources.

#### Sec. 215 Staff Expertise

The additional staff expertise seems appropriate. We suggest also, requiring mental health expertise.

#### Sec. 218 (a) Certificate of Need

The Association supports certificate of need programs and concurs with the intent of the amendment to Part C of Title XV. However, we do not agree with the Administration recommendation that Health Maintenance Organizations be exempted from this program. The Association supports the development of Health Maintenance Organizations and believes that Health Systems Agencies should encourage the establishment of HMO's to meet the needs of the population, and should not be prevented from giving appropriate consideration to the location and establishment of HMO's. Consistent with this philosophy, a representative of a HMO should serve on the HSA governing body.

#### Sec. 219 Appropriateness Review

We urge that establishment of new home health services be approved by the health planning agency. This would eliminate duplication of services and problems created as a result of "for profit groups" getting into home health services.

#### Sec. 220 (b)(2) Review and Approval of Proposed Use of Federal Funds

ANA supports a broader and more proportionate cross-section of representation of consumers and providers on HSA governing boards. We

feel that the legislation should mandate at the minimum one professional nurse position on the governing boards of HSA's.

The governing board has the responsibility for review to approve or disapprove of federally funded grants or contracts for training and research that support the development of health resources intended for the use in the health area or the delivery of health services. We feel professional nursing expertise is needed when there is the review of grants and contracts for nurse training and research. We feel very strongly that all research and training grants should be totally exempted from planning agency review procedures. To require applications that will take researchers or students into health care settings (even where such activities are already ongoing) seems overly restrictive and will slow up the funding process.

Since research and training efforts are focused on meeting national not local goals, we feel they should be exempted.

The development of new health manpower schools does seem an appropriate activity for review.

In this proposal the membership of the National Council on Health Resources and Development is not addressed. When the Council was finally established, the American Nurses' Association was greatly disappointed no professional nurse was named as a member.

We strongly urge that Congress mandate nurse membership on the Council through legislation. ANA requests an amendment to Sec. 1503 (b)(1),



which would require, at the minimum, one seat for a professional nurse.

Several state and local planning groups have made effective use of nurse members on their councils and governing boards. Consumer members appear to work more effectively with those nurses.

The Association generally agrees with the provisions of HR 10460 and believes that full funding and concerted action will result in improvement of the availability and appropriateness of health services.

We hope our suggestions can be incorporated into the final bill.

We ask that this statement be made part of the hearing record.

LAW OFFICES  
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February 24, 1978

Subcommittee on Health  
 Scientific Research  
 Senate Committee on  
 Human Resources  
 Room 4220  
 Dirksen Senate Off. Bldg.  
 Washington, D.C. 20510

Subcommittee on Health and  
 the Environment  
 House Committee on Interstate  
 and Foreign Commerce  
 Room 4226  
 Dirksen Senate Off. Bldg.  
 Washington, D.C. 20510

Re: The Health Planning Amendments of 1978 (S.  
 2410) and The Health Planning and Resource  
 Development Amendments of 1978 (H.R. 10460)

On February 2 and 3, 1978, the above-identified Subcommittees of the Senate and of the House of Representatives received testimony given on behalf of certain so-called "Legal Services clients," including the testimony of Wayne Pressel, an attorney who recently has represented Georgia Legal Services Programs and certain individuals in litigation against the Department of Health, Education, and Welfare and six Georgia Health Systems Agencies created under the Health Planning Act. The litigation, Rakestraw v. Califano, et al., is pending in the Northern District of Georgia, Atlanta Division. Although the Health Systems Agencies, all of whom are represented by the undersigned law firm, have been dismissed from the case by the District Court, Mr. Pressel's clients have petitioned for vacation and revision of that dismissal order.

In his testimony to these Congressional Subcommittees, Mr. Pressel has made many inaccurate and misleading representations with respect to matters at issue in the pending litigation. Sen. Virginia Shapard, president of the North Georgia HSA, has already responded directly to many of the misstated factual representations by a separate letter dated February 22, 1978. Further, our HSA clients have asked that we respond briefly to correct the record and to clarify the confusion which Mr. Pressel's testimony has created.

When lawyers become witnesses for their clients' causes, they lose their credibility. See, for example, Canon 5 of the Code of Professional Responsibility, EC 5-9, which notes as follows:

"An advocate who becomes a witness is in the unseemly and ineffective position of arguing his own credibility."

In this instance, the inaccuracy of so many of Mr. Pressel's factual statements, as pointed out by Senator Shapard, exemplifies the concern which Canon 5 articulates. In his enthusiasm for his clients' cause, Mr. Pressel has lost sight of the facts. He has pursued that cause unsuccessfully in court. He has found that HEW does not agree with his demands. He now turns to Congress as a last resort. If Congress were to permit the development of as complete a record as would be necessary to review fairly Mr. Pressel's contentions, we are confident that the decision reached in this forum would be identical to the decisions previously reached by the federal courts and by HEW affirming the defenses raised by the HSA's.

In truth, Mr. Pressel and his clients are asking that Congress create by new legislation a judicially reviewable right to challenge the qualifications of each and every HSA board member throughout the United States. Every individual who perceives himself as belonging to a special interest group which in his view (or in the view of his attorney) has not been fully represented on an HSA board would have a lawsuit. He could enjoin the HSA from carrying out its responsibilities until a court of law had fully reviewed all the evidence offered by all the parties as to the board member's qualifications, the total composition of the board, the relationship between the composition of the board and the demographics of the community, and the speculative effect which board composition might have on decisions allegedly affecting the special interest group to which the plaintiff belonged.

In the Texas Acorn decision (559 F.2d 1019, copy enclosed) and in the Rakestraw litigation (court's order dismissing HSA defendants dated December 19, 1977 enclosed), several relevant facts ignored in Mr. Pressel's testimony were clearly established.

First, it became clear that litigation over HSA board composition would require years to resolve. During the pendency of that litigation, the HSAs would be severely hampered in their efforts to make the kind of planning decisions which Congress has identified as their principal function.

Second, it became clear that the plaintiffs' interpretation of the Health Planning Act differed considerably both from the court's understanding of the relevant statutory language and from Congressional intent. The plaintiffs, for example, insisted that in order to be an adequate representative of a low income group, an individual must in fact earn no more than the members of the group he sought to represent. The plaintiffs also insisted that the percentage of low income persons on each HSA board must conform to the demographic pattern of the community represented by the Board. Thus, according to plaintiffs, if 65 percent of the persons living in the HSA area earned less than \$10,000 a year, then 65% of the HSA board and its executive committee must earn less than \$10,000 per year.

The practical absurdity of the plaintiffs' argument is clear. For example, the providers on the HSA board would not be likely to earn less than \$10,000 annually. Yet the Act requires that providers constitute no less than 40% of the HSA board. Using the example when 65% of the community earned less than \$10,000 a year, it is obvious that under plaintiffs' interpretation, the statute could not possibly be complied with.

One must also question whether Congress ever intended any HSA board to be composed entirely of providers and the poor. Would such a board be "broadly representative" of the community it served? The answer seems obvious; nevertheless, the "demographic conformity" argument advanced by Mr. Pressel and his clients could have exactly that effect.

The Fifth Circuit in the Texas Acorn decision squarely rejected the plaintiffs' contentions. The court held that under the Health Planning Act, local HSAs were to be given as much discretion as legally permissible to devise their own standards for community representation and for election to the board. The court also held that persons other than those earning \$10,000 dollars or less could be adequate representatives of an economic group composed of such persons. For example, a local politician, an OEO official or a legal services employee could represent poor persons under the Act.

Congress, too, has rejected the plaintiffs' arguments. The Conference Report accompanying H.R. 4975 in July 1977 observed as follows:

"The conferees also wish to clarify the original intent of the Health Planning and Resources Development Act with respect to the composition of governing bodies of Health Systems Agencies. Under the law ... consumer representatives of governing bodies are to be 'broadly representative



of the social, economic, linguistic and racial populations residing within the health service area. The conferees emphasize that, as the law states, the populations are to be broadly represented. Therefore, several different approaches to insuring meaningful involvement in HSA decisions by all segments of society are permissible. In particular, it was not the intention of the Congress in enacting this provision to mandate a quota system requiring the selection of representatives of a particular category strictly proportionate to its representation in the population of the area or to require that representatives of a category be members of the class they represent. Instead, the Congress intended that, in implementation of the requirement with respect to consumer representatives, Health Systems Agencies have the flexibility to adopt selection processes most appropriate to local needs." (Emphasis added).

It is precisely this Congressionally mandated flexibility which Mr. Pressel and his clients now insist should be denied the HSAs.

The six HSAs in Georgia, utilizing the flexibility which Congress has assured them, have complied with the statutory directives in the Health Planning Act. They have selected boards broadly representative of the communities they serve. It is now time that these HSAs be permitted to focus on the critical planning and evaluation functions which the legislation assigns to them.

The plaintiffs' dissatisfaction with the Planning Act, with Congress, with HEW, with the HSAs through the country, and with the federal courts imposes no obligation on this Congress to create new legislation which would embroil the HSAs in endless litigation and effectively would prevent HSAs for the foreseeable future from accomplishing the very objectives underlying the statute. Indeed, if those objectives are to be accomplished, serious consideration should be given to an amendment precluding judicial review of HSA composition.

Board composition can be adequately supervised by HEW, and any party dissatisfied with HEW's decisions in this regard should be limited to administrative challenges within the agency. The balancing of interests which HEW must accomplish in order to decide board composition issues is precisely the sort of function HEW's expertise enables it to perform effectively. Those who are dissatisfied with the



board composition of their local HSAs have no need of federal court protection. To the contrary, from the perspective of any person genuinely concerned with accomplishment of the goals underlying the Health Planning Act, the spectacle of federal judges around the country enjoining all HSA activities while imposing their own definition of "broadly representative" on hundreds of HSAs and thousands of HSA board members is an ominous threat to the entire legislation.

Congress certainly has the power to decide that the board composition issue is not judicially reviewable. See, for example, Section 205(h) of the Social Security Act (42 U.S.C. §405(h)). That power should be exercised in the proposed amendments to the Health Planning Act. Otherwise, the HSAs will be bogged down endlessly in litigation serving no valid public purpose. As Senator Kennedy noted in his remarks opening these hearings, changes in board composition would only slow the HSA process further; the boards should not be "tampered with" at this time if they are to accomplish the objectives intended by Congress.

If this firm or my clients can be of further assistance to the Congressional Subcommittees considering these issues, please advise me. We respectfully request that this submission and Senator Shapard's February 22nd letter be included in the Subcommittees' printed records of these hearings.

Sincerely,

KILPATRICK, CODY, ROGERS,  
McCLATCHEY & REGENSTEIN

By:

A. Stephens Clay  
A. Stephens Clay, for

Health Systems Agency of  
Central Georgia, Inc.

North Central Georgia Health  
Systems Agency, Inc.

Southeast Georgia Health  
Systems, Inc.

Southwest Georgia Health  
Systems Agency, Inc.

East Central Georgia Health  
Systems Agency, Inc.

Enclosures

The modified order affects no one else. Because of mootness, we vacate that portion of the district court's opinion which grants the injunction, so that it will spawn no precedential consequences. We express no opinion on the merits.

AFFIRMED, as modified.



TEXAS ACORN, Dini Turley, et al.,  
Plaintiffs-Appellees,

v.

TEXAS AREA 5 HEALTH SYSTEMS  
AGENCY, INC., Defendant-Appellant,

Joseph Califano, as Secretary, United  
States Department of Health, Education  
and Welfare, Defendant-Appellant,

Floyd A. Norman, M. D., as Regional  
Health Administrator, Public Health  
Service, etc., Defendant.

No. 77-1717.

United States Court of Appeals,  
Fifth Circuit.

Sept. 23, 1977.

Health services consumers brought suit challenging the legality of the Texas Area 5 Health Systems Agency on the ground that its board of directors and executive committee do not adequately represent the social and economic population of Texas Area 5 because the consumer representation includes an insufficient number of persons with annual family incomes below \$10,000. The United States District Court for the Eastern District of Texas, at Sherman, William Wayne Justice, J., granted partial summary judgment for plaintiffs and enjoined the HSA from operating, and an appeal was taken. The Court of Appeals, Thornberry, Circuit Judge, held that (1) al-

though it had jurisdiction over the Department of Health, Education and Welfare, jurisdiction over HSA, the private defendant, was barred by failure to satisfy the amount in controversy requirement, (2) membership of a health systems agency need not conform directly to the demographic breakdown of the area population, nor need an individual on the board of directors or executive committee have an income equal to that of the constituency he or she represents, (3) the trial court, by granting plaintiff summary judgment, improperly failed to give defendants an adequate opportunity to demonstrate the way in which consumer members of the board who make more than \$10,000 per year may be representative of low-income consumers, and to prove that the board was "broadly representative" of the area population, and (4) in reviewing the Secretary of Health, Education and Welfare's decision to approve the board of a health systems agency, the proper standard is whether the Secretary's action was arbitrary, capricious or an abuse of discretion.

Vacated and remanded.

#### 1. Federal Courts ⇐332

Federal question statute's amount in controversy requirement has been removed for suits to review federal agency action. 28 U.S.C.A. § 1331(a).

#### 2. Federal Courts ⇐340

Although, in suit challenging the legality of the Texas Area 5 Health Systems Agency on the ground that its board of directors and executive committee do not adequately represent the social and economic population of Texas Area 5, the district court had federal question jurisdiction over the Department of Health, Education and Welfare, the amount in controversy requirement was not satisfied as to HSA, the private defendant, since the speculative benefits sought by plaintiffs by reconstitution of representation on the board and executive committee could not be reduced to a monetary standard. National Health Planning and Resources Development Act

of 1974, § 2 et seq., 42 U.S.C.A. § 300k et seq.; 28 U.S.C.A. § 1331(a).

### 3. Federal Courts ⇐19

In suit challenging the legality of the Texas Area 5 Health Systems Agency on the ground that its board of directors and executive committee do not adequately represent the social and economic population of Texas Area 5, the HSA could not be brought into the suit as a pendent party unless an independent basis of jurisdiction over it existed. National Health Planning and Resources Development Act of 1974, § 2 et seq., 42 U.S.C.A. § 300k et seq.

### 4. Federal Courts ⇐340, 343

In actions for injunctive and declaratory relief, the jurisdictional amount is the value of the right to be protected or the extent of the injury to be prevented. 28 U.S.C.A. § 1331(a).

### 5. Health and Environment ⇐7(1)

Membership of a health systems agency need not conform directly to the demographic breakdown of the area population, nor need an individual on the board of directors or executive committee have an income equal to that of the constituency he or she represents. National Health Planning and Resources Development Act of 1974, § 1512(b)(3)(C)(i), 42 U.S.C.A. § 3001-1(b)(3)(C)(i).

### 6. Health and Environment ⇐7(1)

Income level is but one factor, albeit perhaps the most important one, in determining who may best represent a particular consumer group, in respect to membership of a health systems agency. National Health Planning and Resources Development Act of 1974, § 1512(b)(3)(C)(i), 42 U.S.C.A. § 3001-1(b)(3)(C)(i).

### 7. Federal Civil Procedure ⇐2512.5

In suit challenging the legality of the Texas Area 5 Health Systems Agency on the ground that its board of directors and executive committee do not represent the social and economic population of Texas Area 5 because the consumer representation includes an insufficient number of persons with annual family incomes below \$10,000,

the trial court, by granting plaintiff summary judgment, improperly failed to give defendants an adequate opportunity to demonstrate the way in which consumer members of the board who make more than \$10,000 per year may be representative of low-income consumers, and to prove that the board was "broadly representative" of the area population. National Health Planning and Resources Development Act of 1974, § 2 et seq., 42 U.S.C.A. § 300k et seq.

### 8. Health and Environment ⇐7(1)

In reviewing the Secretary of Health, Education and Welfare's decision to approve the board of a health systems agency, the proper standard is whether the Secretary's action was arbitrary, capricious or an abuse of discretion. National Health Planning and Resources Development Act of 1974, § 2 et seq., 42 U.S.C.A. § 300k et seq.

Jerry Lee Hughes, Dennis R. Swift, Fort Worth, Tex., Roby Hadden, U.S. Atty., Otis W. Carroll, Jr., Asst. U.S. Atty., Tyler, Tex., Henry L. Gilliam, U.S. Dept. of Health, Education & Welfare, Dallas, Tex., William Kanter, Atty., Paul Blankenstein, Atty., Harry R. Silver, Atty., Civil Div., Appellate Sect., Dept. of Justice, Washington, D.C., for defendants-appellants.

Carl M. Weisbrod, Dallas Legal Services Foundation, Inc., Dallas, Tex., Herbert Semmel Center for Law and Social Policy, Marilyn G. Rose, Washington, D.C., for plaintiffs-appellees.

William D. Wells, NAACP, New York City, J. Francis Pohlhaus, NAACP, Washington, D.C., for amicus curiae.

Appeal from the United States District Court for the Eastern District of Texas.

Before THORNBERRY, AINSWORTH and RONEY, Circuit Judges.

THORNBERRY, Circuit Judge:

Questions striking at the heart of this nation's health planning policy and health resources development permeate this litigation. Plaintiffs, nine individuals and one



unincorporated association (Texas Acorn), gainsay the legality of a Health Systems Agency charged by the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, *et seq.*, with improving the health of area residents, increasing the accessibility to health services, restraining increases in cost, and preventing unnecessary duplication of health resources. 42 U.S.C. § 300l-2. The District Court agreed that the Board of Directors and Executive Committee of the Texas Area 5 Health Systems Agency do not adequately represent the social and economic population of Texas Area 5 because the consumer representation includes an insufficient number of persons with annual family incomes below \$10,000. He granted a partial summary judgment for plaintiffs, and enjoined the Health Systems Agency (HSA) from operating. We reverse and remand for a full evidentiary hearing.

Congress enacted the National Health Planning and Resources Development Act of 1974 (Planning Act)<sup>1</sup> after recognizing several problems with regard to health services in this country, including inflationary increases in their cost and unequal access. Further, the lack of a comprehensive approach to the problem was exacerbating the maldistribution and unnecessary duplication of services already approaching the crisis stage. See 42 U.S.C. § 300k(a). The Act requires the Secretary of the Department of Health, Education and Welfare (HEW) to create health service areas, essentially geographic regions, throughout the United States. 42 U.S.C. 300l. The Secretary has designated twelve of these areas in Texas, over 200 throughout the nation.

1. A direct predecessor of the Planning Act was the Hospital Survey and Construction (Hill-Burton) Act, 42 U.S.C. §§ 291 *et seq.* It provided for federal loans and subsidies for the renovation and construction of health facilities.

2. The statutory scheme actually envisions a three-tiered system. The health systems agency is the organization directly responsible for the development and implementation of health planning at the local level, and for the coordination of national, state, and local health planning. There is a statewide health planning and developing agency (SHPDA) responsible for

Texas Area 5 consists of nineteen counties in the north central part of that state, centering on the Dallas-Fort Worth Region and covering more than 15,000 square miles containing over 3,000,000 people. On September 21, 1976, the Secretary designated defendant, Texas Area 5 Health Systems Agency, Inc., the health systems agency for Texas Area 5, following a struggle between competing entities.<sup>2</sup>

As the statute mandates, health services consumers and providers comprise the Board of Directors and Executive Committee of the HSA. 42 U.S.C. § 300l-1(b)(3)(C). The parties agree, and the District Court found, that approximately 41 of the Board members were consumers, while approximately 38 were providers. The median family income for Texas Area 5 is approximately \$10,000 and three of the 41 consumer members had family incomes below that figure. The Executive Committee also maintains the required consumer majority, 51%-60%, with 13 consumers and 12 providers. Two of the 13 consumers on the Committee had family incomes under \$10,000.

Confronted by these statistics, plaintiffs, all health services consumers, sought declaratory, mandatory, and injunctive relief in the U.S. District Court for the Eastern District of Texas against the Texas Area 5 HSA and HEW. The gravamen of their complaint was the alleged failure of the HSA's Board to include a sufficiently large number of consumers with incomes below \$10,000, and thus its neglect of the statutory mandate to be "broadly representative of the social, economic, linguistic and racial

health planning at the state level. Finally, the Statewide Health Coordinating Councils (SHCC) prepare final state health plans and advise the SHPDA's.

When competing entities vied for the privilege of acting as the Texas Area 5 Health Systems Agency, the Governor of Texas appointed a committee to seek a compromise. HEW had no role in choosing between the competing entities. Rather, it merely approved the application of the compromise group. The HSA received its initial funding from HEW shortly after designation in September, 1976.

populations, geographic areas of the health service area, and major purchasers of health care."<sup>3</sup> 42 U.S.C. § 3001-1(b)(3)(C)(i); 42 CFR 122.109(f)(1). Plaintiffs' Counts I and II concern the alleged under-representation of low income consumers. Plaintiffs also insisted, in Counts III and IV, that the Board's method of selection violated the purposes and provisions of the Planning Act and, in the alternative, that the Planning Act was unconstitutional.

The parties entered into a Stipulation and Agreed Order which enjoined HSA from entering into any contracts or making any grants for health planning. The Order did grant HSA the permission to continue carrying on its day-to-day activities. Plaintiffs then filed a Motion for Partial Summary Judgment on Counts I and II, which the court granted. HSA and HEW have both perfected their appeals from this Order completely enjoining HSA from all operations.

Four issues are paramount. First, there are jurisdictional problems with regard to

the federal (HEW) and private (HSA) defendants. Second, both appellants argue that the District Court erroneously construed the Planning Act to require that a representative of a particular economic stratum have an income which is the same as that of his constituency. Third, the appellants argue that the District Court ignored genuine issues of material fact. Finally, HEW in particular argues that the District Court utilized the wrong standard to review the Secretary's decision.

## I.

[1,2] A. Jurisdiction over HEW. The recent amendment to 28 U.S.C. § 1331(a) removes the amount-in-controversy requirement in suits to review federal agency action.<sup>4</sup> Not surprisingly, HEW declines to argue the jurisdictional point, conceding that the District Court could obtain jurisdiction over it. The Northern District of New York recently reached the same conclusion in a case with similar facts. *Aldamuy v. Pirro*, 436 F.Supp. 1005 (N.D.N.Y. 1977) (Civ. # 76-CV-204).<sup>5</sup>

3. 42 U.S.C. § 3001-1(b)(3)(C)(i) provides in full: The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements: (i) a majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchase of health care.

Section ii further provides that the remaining members shall be providers representing physicians, nurses, health care institutions, health care insurers, health professional schools, and the allied health professions.

4. 28 U.S.C. § 1331(a), as amended, provides: The District Courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of \$10,000, exclusive of interest and costs, and arises under the Constitution, laws or treaties of the United States except that no such sum or value shall be required in any such action brought against the United States, any agency thereof, or any officer or employee thereof in his official capacity.

5. The *Aldamuy* court also notes that the Administrative Procedure Act, 5 U.S.C. §§ 701-06 governs judicial review of the Secretary's approval of the HSA. While that Act does not afford an implied grant of subject-matter jurisdiction permitting federal judicial review of agency action, *Califano v. Sanders*, 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977), the plaintiffs here key their complaint to a specific statutory mandate: 42 U.S.C. § 3001-1(b)(3)(C)(i). Unlike the provision of the Social Security Act that barred judicial review in *Califano*, 42 U.S.C. § 405(g), the National Health Planning and Resources Development Act does not preclude judicial review. The Supreme Court in *Califano* noted that "the obvious effect of this modification [amendment to 28 U.S.C. § 1331(a) removing amount-in-controversy requirement], subject only to preclusion-of-review statutes created or retained by Congress, is to confer jurisdiction on federal courts to review agency action, regardless of whether the APA of its own force may serve as a jurisdictional prerequisite." *Califano*, *supra*, 430 U.S. at 105-106, 97 S.Ct. at 984. See also *Toilet Goods Ass'n v. Gardner*, 387 U.S. 158, 87 S.Ct. 1520, 18 L.Ed.2d 697 (1967) (only upon a showing of clear and convincing evidence of a contrary legislative intent should the courts restrict access to judicial review of administrative action); *Aldamuy v. Pirro*, *supra*.



[3] B. Jurisdiction over HSA. The amendment to 28 U.S.C. § 1331(a) removes the amount-in-controversy requirement as to the federal defendant but it has no effect on the HSA. The appellees argue that we can obtain jurisdiction over the HSA by using § 1331(a) and exercising pendent jurisdiction. Since the action is against the United States, the pendent jurisdiction doctrines allegedly permit joinder of non-federal defendants. Appellees argue to no avail. The HSA may not be brought into the suit as pendent parties unless an independent basis of jurisdiction over it exists. See *Al-dinger v. Howard*, 427 U.S. 1, 96 S.Ct. 2413, 49 L.Ed.2d 276 (1976).

[4] Appellees cannot satisfy the amount-in-controversy requirement. They have not offered any evidence of potential or direct injury to themselves, beyond merely pointing out that the HSA has received funds totalling \$771,535 from HEW and will probably receive millions of dollars within the next several years. Surely a plaintiff cannot satisfy the jurisdictional amount any time a private defendant's annual budget exceeds \$10,000. See *Aldamuy*, *supra*; *Carman v. Richardson*, 357 F.Supp. 1148 (D.Vt.1973). In actions for injunctive and declaratory relief, the jurisdictional amount is the value of the right to be protected or the extent of the injury to be prevented. *Mississippi & M.R. Co. v. Ward*, 67 U.S. (2 Black) 485, 17 L.Ed. 311 (1867); *Flato Realty Invs. v. City of Big Spring*, 388 F.Supp. 131 (N.D.Tex.1975), *aff'd without opinion*, 519 F.2d 1087 (5 Cir. 1975); 14 Wright, Miller & Cooper, Federal Practice and Procedure: Jurisdiction § 3708.<sup>6</sup>

Plaintiffs do not seek the permanent cessation of all funds to the Texas Area 5 HSA, nor do they claim that \$771,535 is excessive. Quite the contrary, plaintiffs

deem themselves major beneficiaries of the funding, and demand an end to an alleged deprivation of their right of adequate representation on the Board. They seek reconstitution, not abolition. Their object is not direct participation in the budget, but the right to adequate representation on the Board and Committee, specifically that the Board have more members with incomes less than \$10,000. The injury to each individual plaintiff,<sup>7</sup> even if we could reduce it to a monetary standard, would be small indeed. Since each plaintiff's claim is separate and distinct, each must rest on its own independent jurisdictional amount. Plaintiffs cannot aggregate them. *Zahn v. International Paper Co.*, 414 U.S. 291, 94 S.Ct. 505, 38 L.Ed.2d 511 (1973); *Clark v. Gray*, 306 U.S. 583, 59 S.Ct. 744, 83 L.Ed. 1001 (1939).

In fact, plaintiffs cannot reduce such a speculative benefit to a monetary standard, so there is no pecuniary amount in controversy. See, e. g., *Hague v. CIO*, 307 U.S. 496, 59 S.Ct. 954, 83 L.Ed. 1423 (1939); *Amen v. City of Dearborn*, 532 F.2d 554 (6 Cir. 1976); *Senate Select Committee on Presidential Campaign Activities v. Nixon*, 366 F.Supp. 51 (D.C.D.C.1973). Plaintiffs admit that the injury they complain of is not that any specific decisions of the HSA will be altered, but that they have suffered a denial of "representational rights" granted by 42 U.S.C. § 3001-1(b)(3). (R. 219). A monetary standard requires an injury far less conjectural and speculative than this alleged dilution of representation on an HSA Board. Plaintiffs failed to demonstrate even an approximate dollar value of the relief sought or alleged injury. That failure is no surprise, since such a task would be impossible. Even if a dollar figure could be placed on representational rights on an HSA Board, the amount would

6. This is a general rule, applicable to other causes of action as well. See, e. g., *Koster v. Lumbermens Mut. Cas. Co.*, 330 U.S. 518, 67 S.Ct. 828, 91 L.Ed. 1067 (1947); *Kimball v. Callahan*, 493 F.2d 564 (9 Cir., 1974), *cert. denied*, 419 U.S. 1019, 95 S.Ct. 491, 42 L.Ed.2d 292 (1974); *Waller v. Professional Ins. Corp.*, 296 F.2d 545 (5 Cir., 1961).

7. Texas Acorn asserts that it is an unincorporated association with state-wide membership composed of Texas residents with low to moderate family income levels. At least 1500 families are members. (R. 395).

be insignificant.<sup>8</sup> On the basis of the record, the District Court committed clear error in holding that the jurisdictional sum had been met.<sup>9</sup>

## II.

Appellant submits a two-pronged attack on the District Court's construction of § 3001-1(b)(3)(C)(i), since the court interpreted the provision to mean that the membership of the governing bodies must correlate with an economic and demographic study of Texas Area 5, and also that an individual must have an annual income less than the median to represent the lower economic strata. Neither interpretation is accurate.

[5] The district court relied on a preamble to the HSA regulations to support his holding that 50 percent, with an allowable variance of up to 10%, of the Board must be persons with a family income below the median. The preamble stated that the "consumer majority should roughly approximate, in its representational aspects, the whole population of the health service area." 41 Fed.Reg. 12812, 12820 (March 26, 1976).<sup>10</sup> We reject the notion that the terms "broadly representative" and "roughly approximate" require the application of a formula to produce a governing body whose consumer membership is evenly divided between persons whose income is below and those whose income is above the median for

the area. Instead, we hold that phrases like "extreme complexity and variety," "as much discretion as legally permissible," and "does not necessitate an equal proportion," all also found in the same preamble,<sup>11</sup> demonstrate beyond cavil that the Secretary is encouraging, not a rigid formula, but broad community representation so that the Board will invariably consider the needs of diverse groups in the community. Certainly the health needs of our low income citizens are crucial, and undeniably the HSA's must listen to their voices. Nowhere, however, does Congress or the Secretary state that the membership on the Board has to conform directly to the demographic breakdown of the area population.

[6] Nor does Congress or the Secretary insist that an individual must have an income equal to that of the constituency he or she represents. Indeed, the proposed "Draft Guidelines Covering Governing Bodies for Health Systems Agencies" (October, 1976) circulated by HEW, listed a wide variety of useful skills for governing body members, including *inter alia*, experience on deliberative bodies and in leading meetings, skill in communicating with a variety of community groups, demonstrated ability to negotiate and mediate, understanding and appreciation of different perspectives in the community, credibility with community groups, legal training and experience.<sup>12</sup> In

8. Though perhaps valuable, representational rights on an HSA Board of Directors certainly do not rise to the level of a constitutional guarantee. Yet even in cases where fundamental constitutional rights are at stake, satisfaction of the amount in controversy is a prerequisite to jurisdiction under § 1331. See, e.g., *Lynch v. Household Fin. Corp.*, 405 U.S. 538, 92 S.Ct. 1113, 31 L.Ed.2d 424 (1972).

9. We wonder whether this point has much ultimate significance. Surely the HSA would be seeking to intervene, were the litigation to continue against HEW without it.

10. The preamble states in full:

Recognizing the extreme complexity and variety in designated health service areas, the Department wishes, at this stage, to give as much discretion as legally permissible to health systems agencies. The Department does state that in its view although the term "broadly representative" does not necessitate

an equal proportion, it does indicate that the consumer majority should roughly approximate, in its representational aspects, the whole population of the health service area.

11. See n. 10, *supra*.

12. R. 133. See also Report of Committee on Interstate and Foreign Commerce's first annual review of the Planning Act, which stated:

This ["broadly representative" requirement] has led to expectable debate over whether adequate representation has been given to poor people, rural areas, women and so forth. Here there is a need in the future to strike a difficult balance between assuring, on the one hand, that all parties are adequately represented and requiring, on the other hand, representation so rigidly proportional to various people's proportion of the population that the process is paralyzed by the requirements. H.R.REP.NO.95-116, 95th Cong., 1st Sess. 12 (March 26, 1977).

r words, income level is but one factor, it perhaps the most important one, in determining who may best represent a particular consumer group, be it low-income or otherwise. A number of elements create most articulate champions of low-income consumers, and application of a rigid demographic formula could conceivably thwart the most effective expression of advocacy of the interests of all segments of the consumer population of a health service area.<sup>13</sup>

### III.

The District Court entertained no evidence before determining that only persons with incomes below the median could represent low-income consumers, and holding that low-income consumer representation was inadequate. Admittedly, HEW created problems for itself with its reply to an interrogatory asking the names of members who are representative of low income consumers. HEW responded by listing four Board members, one of whom was a provider, whose incomes were under \$10,000. (R. 395).

In its brief, HEW admits that it phrased the answer poorly, and explains that it attempted to identify those Board members who fall into the low income category. The HEW did not intend to list all persons who represent low income consumers on the Board, nor did it intend to admit that the Board is not "broadly representative." (Brief at 23-24). Whether or not HEW's response was an honest mistake or poor articulation, no one can deny that the HEW

took the position throughout the proceedings and in the District Court that there is no requirement that low income consumer representatives have low incomes. It is also of record that HEW denied plaintiffs' allegation that the Board was not broadly representative of the low and moderate income consumers of Texas Area 5. (HEW Answer to ¶ 14 of the Complaint).

[7] HEW also relies on the HSA's response to the same interrogatory. Although we have found that the court has no jurisdiction over the HSA, the District Court considered the HSA's answers and yet ignored their import. The HSA identified some 29 members of the Board whom they deemed representative of low and moderate income consumers. In its answer, the HSA listed five criteria which it used in selecting the membership of the Board.<sup>14</sup>

These 29 members all had been selected on the basis of one or more of the criteria. Some of the criteria would seem to insure representation of groups overlapping with but not congruent to the low income consumer segment of the population (minorities, for example), but the point is again that we do not believe that only consumers with low incomes can represent low income consumers. The trial court, by granting summary judgment, did not give defendants an adequate opportunity to demonstrate the way in which consumer members of the Board who make more than \$10,000 per year may be representative of low income consumers, and to prove that the Board was "broadly representative" of the

13. A recent Conference Committee Report buttresses our conclusion that the income and representation guidelines are flexible ones. The Report, which concerns amendments to the Public Health Service Act under HR 49-75, states in pertinent part as follows:

"The conferees also wish to clarify the original intent of the Health Planning and Resources Development Act with respect to the composition of governing bodies of health systems agencies. \* \* \* In particular, it was not the intent of Congress . . . to mandate a quota system requiring the selection of representatives of a particular category strictly proportionate to its representation in the population of the area or to require that representa-

tives of a category be members of the class they represent. Instead, the Congress intended that . . . health systems agencies have the flexibility to adopt selection processes most appropriate to local needs." *Congressional Record*, H 7121, at H 7127 (July 14, 1977).

14. The five criteria included: "income of less than \$15,000; a member of an ethnic minority; a public official or employee of a Federal agency; a representative designated by the coalition of community action agencies which formed a part of the compromise application; and representatives of consumer and other groups." (R. 335).



area population. The HEW had no opportunity to develop the facts which would have aided their defense of the HSA Board.

The failure to hold an evidentiary hearing is more unfortunate where, as here, the litigation involves issues of major public importance. In the words of the Supreme Court, "Judgment on issues of public moment based on such evidence [affidavits], not subject to probing by judge and opposing counsel, is apt to be treacherous." *Eccles v. Peoples Bank of Lakewood Village, Ca.*, 333 U.S. 426, 434, 68 S.Ct. 641, 645, 92 L.Ed. 784 (1948). See also *Kennedy v. Silas Mason Co.*, 334 U.S. 249, 68 S.Ct. 1031, 92 L.Ed. 1347 (1948); *Sinderman v. Perry*, 430 F.2d 939 (5 Cir., 1970), *aff'd*, 408 U.S. 593, 92 S.Ct. 2694, 33 L.Ed.2d 570 (1972). The HSA's around the country form the foundation of a major new federal health planning program. This litigation involves judicial construction of statutory requirements concerning the membership of HSA's governing bodies, and judicial intrusion into the administrative realm. The result here will set precedent for the plight of all HSA's, and could have a major effect on the national health plan. Courts must make certain that conclusions in cases involving important public questions rest on definite factual foundations. The conclusions in the instant case do not.

#### IV.

One of the strongest holdings of *Aldamuy*, *supra*, concerns the appropriate standard of review. There, the court held unequivocally that it had to find that the HEW Secretary's decision to approve the Board of an HSA was arbitrary, capricious, or an abuse of discretion before overturning it. It is not enough that one could take issue with the Secretary's decision, or that

one feels other individuals might better represent certain concerns. The Secretary must balance a large number of factors in approving an HSA, and its judgment is entitled to some deference. HEW has the expertise in the health planning field. The courts do not. See also *U. S. v. Shimer*, 367 U.S. 374, 81 S.Ct. 1554, 6 L.Ed.2d 908 (1961).

Texas Acorn attempts to distinguish *Aldamuy*, and certainly it and the instant case are not identical. The dispute in *Aldamuy* was between various groups of blacks, who disagreed with each other as to which blacks would truly represent blacks. The complainants insisted that the minority members of the Board of the Central New York HSA did not really represent the minority community.<sup>15</sup>

Numerically, however, minorities were, if anything, overrepresented on the Board.<sup>16</sup>

[8] Although the situations are different, the Secretary in either case has a similar task of attempting to juggle numerous demographic factors and policy concerns. The Secretary must ascertain that the Board includes a proper balance of providers and consumers, and that the membership roughly reflects the population distribution of the various counties in the health service area—19 counties in Texas Area 5. The membership must include elected public officials and other representatives of governmental authorities. A certain percentage of non-metropolitan individuals must be on the Board. 42 U.S.C. § 3001-1(b)(C). The Secretary's approval is, in effect, an accommodation of policy alternatives. We find that the proper standard is whether the Secretary's action was arbitrary, capricious or an abuse of discretion. We instruct the trial court to try the case in light of that standard.

15. Plaintiffs also claimed that no one on the Board represented the inner city, and that the presence of government officials on the Board was a subterfuge. The statute negates the arguments. It nowhere requires inner city representation, and indeed, the only geographic area specifically mentioned is the non-metropolitan. Further, the statute mandates that the Board

include public elected officials and other representatives of governmental authorities. 42 U.S.C. § 3001-1(b)(3)(C)(iii)(I) and (II).

16. Though only 3.1% of the Central New York Area is non-white, 14% of the consumer members of the Board were non-white.

Vacated and remanded for an evidentiary hearing in accord with this opinion.<sup>17</sup>



Myrl E. ETHERIDGE and Billy E. Etheridge, Permanent Administrator of the Estate of Edwin E. Etheridge, Plaintiffs-Appellants,

v.

PIPER AIRCRAFT CORPORATION,  
Defendant-Appellee.

No. 75-4306.

United States Court of Appeals,  
Fifth Circuit.

Sept. 23, 1977.

Parents of decedent, whose death resulted from airplane crash, brought action against manufacturer of airplane, and manufacturer moved for dismissal for lack of subject matter jurisdiction. The United States District Court for the Southern District of Florida, C. Clyde Atkins, Chief Judge, granted the motion to dismiss, and parents appealed. The Court of Appeals, Lewis R. Morgan, Circuit Judge, held that even if Florida Wrongful Death Act applied, where funeral expenses paid by decedent's parents totaled \$3,300, where decedent, immediately prior to his death, was 21 years old and was apparently in good health, and where decedent had mowed grass and performed household duties for his parents, dismissal on ground that amount in controversy did not amount to \$10,000 was not warranted.

Reversed.

17. At oral argument, HEW requested that we remand and order the trial court to wait for forthcoming HEW Regulations and an express administrative determination of whether the Texas Area 5 HSA is in compliance with them. Both the HSA and Texas Acorn opposed that course of action, and we concur. HEW could

## 1. Federal Courts ⇐339

Under statute setting forth jurisdictional amount requirement for diversity cases, court will first look to sum demanded by plaintiff in order to determine amount in controversy, and improbability of recovery is not sufficient basis for denial of jurisdiction. 28 U.S.C.A. § 1332.

## 2. Federal Courts ⇐341

Even if Florida Wrongful Death Act applied in action brought against airplane manufacturer, by parents of individual who died as a result of airplane crash, where funeral expenses paid by parents totaled \$3,300, where decedent, immediately prior to his death, was 21 years old and was apparently in good health, and where decedent had mowed grass and performed household duties for his parents, although no one had been hired to fulfill those duties, dismissal of complaint on ground that amount in controversy did not amount to \$10,000 was not warranted. West's F.S.A. §§ 768.16 et seq., 768.20, 768.21(1, 5); 28 U.S.C.A. § 1332.

## 3. Death ⇐87

Under Florida law, it is not necessary to hire others as replacements for decedent in order to recover damages in a wrongful death action for loss of decedent's services. West's F.S.A. §§ 768.16 et seq., 768.21(1).

Warren A. Rosser, Eugene R. Kiser, Atlanta, Ga., Virginia B. Garrett, Douglasville, Ga., for plaintiffs-appellants.

Howard E. Barwick, David L. Wills, Miami, Fla., for defendant-appellee.

Appeal from the United States District Court for the Southern District of Florida.

not say with any certainty when the Secretary would issue the Regulations, and we consider the issues too important to countenance waiting indefinitely. If the Regulations mandate a dramatic change, either the lower court or this court can deal with them at the appropriate time.



DEC 19 1977

UNITED STATES DISTRICT COURT  
 NORTHERN DISTRICT OF GEORGIA  
 ATLANTA DIVISION

W. H. CARTER, CLERK  
 DEPUTY CLERK

LUCIUS RAKESTRAW, et al :  
 VERSUS : CIVIL ACTION NO. C-77-635-A  
 JOSEPH A. CALIFANO, et al :

O R D E R

This action challenging the composition of the governing bodies of certain Health Systems Agencies (hereinafter referred to as "HSA's") and seeking declaratory and injunctive relief was stayed pending a decision in a similar case before the Fifth Circuit Court of Appeals. That case has now been decided, Texas Acorn v. Texas Area 5 Health Systems Agencies, 559 F.2d 1019 (5th Cir. 1977), and the parties have submitted briefs as directed. Presently pending are the plaintiffs' motion for revision of the order of August 20, 1977, their motion to vacate the protective order, two motions to amend the complaint and motions to dismiss filed by the HSA defendants.<sup>1/</sup>

Subject matter jurisdiction is predicated upon 28 U.S.C. §1331 and the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §300k et seq. (hereinafter referred to as "the Health Planning Act"). As noted by the court in Texas Acorn, the recent amendment to the federal question statute removes the amount-in-controversy requirement in suits to review federal agency action. Unlike the statute before the Supreme Court in Califano v. Sanders, 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192

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 1/ The Appalachian Georgia Health Systems Agency, Inc., filed a separate motion to dismiss while the remaining five other HSA defendants submitted a joint motion. Since both motions raise the same issues, they will be treated jointly in this order.

(1977) the Health Planning Act does not contain a preclusion-of-review provision, and agency action thereunder is subject to judicial review pursuant to the Administrative Procedure Act, 5 U.S.C. §§701-06. Therefore, there is subject matter jurisdiction with respect to claims against the federal defendant and the plaintiff is not required to meet the jurisdictional amount.

Jurisdiction over claims against the nonfederal defendants is another matter. As the court of appeals noted, they may not be brought in as pendant parties unless there is an independent basis for jurisdiction, see Aldinger v. Howard, 427 U.S. 1, 96 S.Ct 2413, 49 L.Ed.2d 276 (1976); and the amount-in-controversy criteria must be met. Texas Acorn, supra at 1023.

The HSA defendants move for dismissal under Texas Acorn claiming that there is no private right of action contained in the Health Planning Act, and that even if there were, the plaintiffs cannot satisfy the jurisdictional amount. Disposition of the plaintiffs' pending motions will be affected by the result reached on the defendants' motion to dismiss. If the causes of action against the private defendants are not supported by the jurisdictional amount, the claim of "new evidence" against the governor of Georgia cannot revive a case against him and reverse his earlier dismissal. So, the plaintiffs' proposed amendments would be irrelevant and subject to summary dismissal, and the motion to vacate the protective order would be moot. Consequently, the motions to dismiss will be decided first.

In Texas Acorn, the Fifth Circuit Court of Appeals found no subject matter jurisdiction against the private defendant, HSA, rejecting the theory that the agency's budget, if in excess of \$10,000.00, would satisfy the jurisdictional amount. As the court noted, the amount in controversy in an action for injunctive and declaratory relief is the value of the right to be protected

or the extent of the injury to be prevented, and:

Plaintiffs do not seek the permanent cessation of all funds to the Texas Area 5 HSA, nor do they claim that \$771,535 is excessive. Quite the contrary, plaintiffs deem themselves major beneficiaries of the funding, and demand an end to an alleged deprivation of their right of adequate representation on the Board. They seek reconstitution, not abolition. Their object is not direct participation in the budget, but the right to adequate representation on the Board and Committee, specifically that the Board have more members with incomes less than \$10,000. The injury to each individual plaintiff, even if we could reduce it to a monetary standard, would be small indeed. Since each plaintiff's claim is separate and distinct, each must rest on its own independent jurisdictional amount. Plaintiffs cannot aggregate them....

In fact, plaintiffs cannot reduce such a speculative benefit to a monetary standard, so there is no pecuniary amount in controversy.... Plaintiffs admit that the injury they complain of is not that any specific decisions of the HSA will be altered, but that they have suffered a denial of "representational rights" granted by 42 U.S.C. §300L-1(b)(3). (R.219). A monetary standard requires an injury far less conjectural and speculative than this alleged dilution of representation on an HSA Board. Plaintiffs failed to demonstrate even an approximate dollar value of the relief sought or alleged injury. That failure is no surprise, since such a task would be impossible. Even if a dollar figure could be placed on representational rights on an HSA Board, the amount would be insignificant. (footnotes and citations omitted).

559 F.2d at 1023. In footnote 8, page 1024, the court observed that the plaintiffs' representational rights do not rise to a constitutional level.

The plaintiffs attempt to avoid this reasoning, first insisting that they have at least a right to demonstrate by evidence the potential or direct injury to themselves. However, their subsequent analysis of the effect of decisions to be made by the HSA boards goes directly to the "speculative benefits" addressed by the court of appeals and ignores the fact that the court has said that such benefits cannot be reduced to a monetary

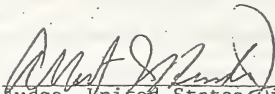
standard as such a task would be impossible. Here, as in Texas Acorn, the plaintiffs seek reconstitution of the HSA boards -- not abolition. They can only speculate that specific decisions of the boards would thus be altered, and any corresponding impact of these decisions is even more remote. The HSA defendants are entitled to dismissal for lack of subject matter jurisdiction under the rationale of Texas Acorn. The question of a private right of action under the Health Planning Act need not be reached in this instance and was not impliedly decided by the court of appeals in Texas Acorn. Assuming arguendo that a private right of action exists under the statute, the plaintiffs would still be required to meet the jurisdictional amount and they are unable to do so. The plaintiffs still have a federal remedy against HEW, however, as noted earlier.

Dismissal of the HSA defendants defeats the plaintiffs' pending motions. The proposed amendment to allege an amount in controversy is subject to summary dismissal. The proffered amended cause of action against the HSA defendants for refusal to make agency records available under the Health Planning Act is procedurally and substantively without merit and mooted by the dismissal of the HSA's. The plaintiffs' motion to vacate the protective order as it applies to two HSA defendants is likewise moot.

The plaintiffs also submitted "new evidence" of the alleged involvement of the governor in the designation of HSA's. The evidence goes only to the existence of a preliminary state plan working toward a designation agreement by 1980 and does not alter the conclusions reached before. Even if such evidence did support a claim against the governor, the plaintiffs again would be unable to prove the jurisdictional amount.

Accordingly, the HSA's motions to dismiss for lack of subject matter jurisdiction are granted. The plaintiffs' motions to amend, motion to vacate the protective order and motion for revision of the order of August 20, 1977, are denied.

So ordered this the 19 day of December, 1977.

  
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Judge, United States District Court  
for the Northern District of Georgia



TESTIMONY

of

Louis A. Finney, M.D.

in behalf of the

American Association of Neurological Surgeons  
and the  
Congress of Neurological Surgeons

BEFORE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

UNITED STATES HOUSE OF REPRESENTATIVES

However, we have significant concern regarding the health planning process. Congress will have to review the function of the existing bodies annually to determine if changes are needed. We are concerned over excessive government influence at the federal, state and local levels and fear the autocratic use of governmental power. We are disturbed over duplicative planning emanating from government sources other than those specified under this Act. All provider groups seem to feel that they are deserving of more input into any governmentally regulated planning activity. Every involved entity fears that the planning process may ultimately lead to regulation of the health care industry in ways similar to the current regulation of utilities. Congress must guard against all of these undesirable considerations and using their power of oversight, must extend the Health Planning and Resources Development Act for one year only.

We urge Congress to carefully monitor activities of of the various authorized entities to see if additional health care expertise should not be provided by future amendments. The neurosurgical community

has advocated a National Advisory Panel for Neurosurgical Data.

In order to improve the national health planning effort in a realistic fashion it would be quite germane for Congress at this time to consider a National Advisory Panel for Neurosurgical Planning and similar panels for other specialties.

Until passage of the Health Planning & Resources Development Act federal health programs were approved by Congress, managed by the administration, and the responsibility of the Public Health Service and Surgeon General. The Health Planning and Resources Development Act created a series of advisory bodies which might best be considered as an attempt both at decentralization and a response to the desire for a consensus opinion at local and state levels in planning for the proper delivery of health care. Unfortunately, this has resulted in health care planning becoming ever more political. It would appear that results will not be the desired consensus but will be a never ending series of political compromises between competing entities.

Congress is now considering proposals obviously intended to increase the power of state and local governments and their authority over the Health Systems Agencies. It is only reasonable to expect the state health plan to be approved by the governor. The governor should not have the authority to veto the state health plan. Should veto power be granted to the governor, the entire effort of the Health Planning and Resources Development Act becomes meaningless.

Unfortunately, at this time there are examples where health planning through state agencies is producing directions and goals at variance from those developed by the Health Systems Agencies and the Statewide Health Coordinating Councils. Congress must encourage the federal and state governments to subserve the same purpose. It would be wise to allow state executives additional input into the formulation of the state health plan, but Congress must guard against autocratic influence being exerted on this seemingly democratic effort of the citizens by any governor. Accordingly, we are opposed to the governor appointing the chairman of the Statewide Health Coordinating Councils and favor proposals allowing the members of the Statewide Health Coordinating Council to elect their own chairperson with a mandated maximum time limit for the chairmanship.

In addition we are opposed to the governor having authority to release funds for projects disapproved of by Health Systems Agencies. Such powers would negate the apparent democratic process of the Health Planning and Resources Development Act. A more logical solution would be to give the state executive department authority to request consideration of specific issues by the Health Systems Agencies and the Statewide Health Coordinating Councils. If the Secretary of Health, Education and Welfare can decree national health plans and goals, the governors should have comparable authority at the state level. However, undue state executive control will dilute the deliberation of the Health Systems Agencies back to a review and comment posture. Then the governor would have power to implement whatever program he might deem in the best interests of his friends or of his political party. Congress must carefully determine the relative strengths of the state executive and the planning processes of this Act so that a creative and democratic atmosphere can be maintained.

Congress must also insist that state health plans in general should conform to a uniform format with room for exceptions. We accept the fact that state health plans should determine the optimum number



of personnel, facilities, and health services within the states. It is only reasonable that the state health plans coordinate with state mental health plans. We also support proposals to ensure that the state plans also contain sections incorporating state activities regarding public health, community mental health, alcohol abuse and drug abuse.

We object to the state having authority to establish priorities for any problem considered a state wide problem rather than a local problem. There may be many health problems localized within specific areas of state which are of greater medical significance than statewide problems. Geographically restricted or socially confined medical problems should not be deprived of priority status because of their "local" occurrence.

The demand for rural representation on the Statewide Health Coordinating Councils is readily appreciated as is the demand for greater urban representation on the same council. We are not opposed to representation in the Statewide Health Coordinating Councils based upon the population density of the respective Health Systems Agencies but we do not favor giving additional representation to any groups for geographic or social reasons.

A few observations concerning local government participation in health planning are now pertinent. We have no objection to revision of boundaries of Health Systems Agencies if the new boundaries "would more appropriately meet the designation of the Health Systems Agency as required by law". However, such a provision may result in constant gerrymandering of Health Systems Agencies. It is our steadfast belief that the Health Systems Agency boundaries should represent catchment patient referral patterns in an area rather than non-realistic and abstract geographical lines. At this time we are opposed to allowing Health Systems Agencies incorporating standard metropolitan areas in more than one state to be broken down into separate Health Systems Agencies at the whim of a single governor. Historically health care delivery has recognized neither state lines nor national boundaries. Accordingly, any artificial subdivision of health care delivery systems on the basis of state lines should not be condoned in the extension of this Act.

It is understandable with the difficulties encountered in responding to and conforming to the existing law, that the conditional designation of the Health Systems Agencies be lengthened to 24 months. We

concur that priorities should be given to those Health Systems Agency applications that receive approval of the governor.

Further, we endorse provisions that consider business meetings on personnel and data of the Health Systems Agencies as confidential. However, in compliance with the freedom of information and government in the sunshine statutes, we urge that minutes of the executive committee meetings of Health Systems Agencies and Statewide Health Coordinating Councils be available for public review and scrutiny.

It is desirable that the staff of the Health Systems Agency have skills in financial and economic analysis as well as in health and public health.

We urge favorable action on amendments to allow the Health Systems Agencies to carry over funds from year to year rather than having to spend all funds in the year of appropriation.

The allowance of Health Systems Agencies to accept money from insurance carriers and from non-profit tax exempt entities will only lead to incidents where undue influence through the granting of monies will

be exerted upon the Health Systems Agencies. It is ethically desirable that Health Systems Agencies operate within very strict and protective guidelines. If the Congress desires purely scientific and humanitarian societies as foundations to be able to financially assist the planning process, then precise authorization must be written to this effect.

Historically the financial and power structure of any community has maintained a paternal relationship toward the local medical profession and health care entities. This fact is well recognized by the neurosurgical community. We observe with interest those proposals which encourage corporations to seek membership on the consumer portion of Health Systems Agencies. This corporate leadership in health planning has already been accepted in the new format as well as it was in the old informal fashion in a few large industry communities such as Rochester, New York and Akron, Ohio. As a result we have no objection to the law encouraging either corporations or labor organizations to seek membership on the consumer section of the Health Systems Agencies.

We approve proposals that spell out specific instances of conflicts of interest which would preclude members of Health Systems Agencies from voting on certain projects. However, we do not feel that a spouse of a provider must be considered as a provider. Our impression is that a spouse of a provider should be considered a consumer with the sole restriction on the activities of the spouse of a provider being strict adherence to the conflict of interest restrictions which would carry over from the provider to his or her spouse.

We also support amendments requiring providers to have a residency or a business in the area of the specific Health Systems Agency in order for them to be considered as provider members. Further, we support the amendment that indirect providers cannot serve as consumers for twelve months after they cease their business which designates them as indirect providers.

Until provider membership is broadened we must emphatically object to the placement of deans of medical schools within a health service area on the governing board of the local Health Systems Agency. Most deans will merit such a position without Congress having to guarantee this seat. Such an act of Congress will lead to similar and equally unacceptable demands from deans of dental schools, public health schools, nursing schools and officials of other entities.



The same reasoning must be given for objection to the request that twenty-five per cent of the total number of seats be given to elected officials of public government. If a certain percentage of Health Systems Agency seats are designated for elected officials of local government, these seats should come exclusively from those allocated to consumers.

We have previously commented in favor of integrating state mental health plans into the state health plan and therefore strongly oppose allocating one of the provider seats to a representative of a local mental health governing board. It would seem advisable for the mental health governing board to present their actions to the local Health Systems Agency for review and comment. Another alternative would be for designating the mental health governing board as a subordinate entity to the Health Systems Agency.

However, we do approve strengthening of the local government input into the health planning process by endorsement of provisions forbidding delegation to Health Systems Agencies by public governing bodies of basic personnel decisions or the budget of the Health Systems Agency. In addition, we agree that members of the Health Systems Agency be reimbursed for services and for travel.

The need for individuals to be trained in the planning process is recognized and naturally we support programs to educate members of the governing boards of Health Systems Agencies as a realistic alternative to the election or appointment of informed individuals to these positions.

Proposed revisions of Certificate of Need provisions are worthy of comment. Certificates of Need should not be required for capital expenditures exceeding \$150,000 by entities not considered facilities or hospitals. This will allow private enterprise to offer services in competition with those elements of the health care delivery system now regulated in a manner similar to the regulation of a utility. Therefore, we support the Subcommittee on Health and the Environment amendment that equipment purchases by non-institutional providers will be subject to Certificate of Need review only when the equipment is intended for use by a hospital.

In these days of escalating construction costs delay in the initiation of a project is understandable. Certificates of Need should not be withdrawn unless any delay in development of a project were unreasonable or it was determined that the holders of the Certificate of Need were

using their permit solely to block competing institutions or agencies from developing those services needed by the community.

It is also desirable that the Secretary of Health, Education and Welfare review National Guidelines for Health annually and that he also make periodic statements on the rate at which the goals are being obtained. We concur with the Subcommittee on Health and the Environment that local health plans be consistent with the national guidelines. Congress must precisely define that the guidelines are not directives from the Department of Health, Education and Welfare and that the Health Systems Agencies have the final judgement on their local areas. Exceptions to the guidelines by rural areas should be authorized by the law. The guidelines should encourage improvement of rural health care delivery and enhance a system approach to health care in isolated areas.

We are concerned over the undue efforts by rural areas to ensure a stronger voice in the health planning process. We feel that this will be detrimental to the development of health care in the United States. Rapid transportation to larger medical centers and the inability of small rural hospitals to offer a multiplicity of services should make even the greatest proponents of rural medicine realize that many

medical conditions are now and will continue to be referred to centers staffed and equipped to handle the specific problems. Therefore inclusion of the Assistant Secretary for Rural Development of the Department of Agriculture to the National Council of Health Planning and Resources Development is unnecessary. Subarea councils under Health Systems Agencies should not be approved for rural areas as they would be in opposition to the intent of the original law. However, we do support grants favoring rural areas and additional grant monies being allocated to underserved rural areas.

The Secretary of Health, Education and Welfare should also adopt policies to monitor the cost of health care but we would suggest that he point out excessive and inappropriate expenditures for health care rather than attempt to "contain the cost of health care". Promotion of efficiency in the delivery of health care is just as acceptable national goal as is the assurance of more appropriate use of health care.

The Secretary of Health, Education and Welfare should be required to renew each Health Systems Agency annually and make commentary on its function. We concur in review of the appropriateness of services rendered by institutions only upon request by the state health plan or by the Secretary of Health, Education and Welfare. Annual review

would seem to be unnecessary and prohibitively expensive. It would seem impossible for the Health Systems Agencies to review home health services although the agencies should be advised to encourage the development of such services within their areas.

We are concerned over the desire to close hospitals although this may be necessary in some regions. Problems may arise by offering grants to discontinue duplicative services as well as grants equal to the cost of conversion or for the liquidation of the hospital. In problem areas this may allow inefficient institutional governing boards and avaricious proprietors to reap profits through the deliberate mismanagement of health service facilities. Certainly a grant having to equal the cost of liquidation of a hospital would seem to encourage unscrupulous entrepreneurs in the health care delivery field. Also, we feel that services of institutions deemed inappropriate be withdrawn only after some acceptable procedure to guarantee due process for all persons involved.

Further, in these days of escalation of health care costs it seems implausible for a Health Systems Agency to guarantee that the per capita patient cost in a entire area will have to diminish before withdrawal of services will be permitted.



At this time the neurosurgical community is adamantly opposed to any authority being given for the coordination of activities of Health Systems Agencies with other entities that review rates and budgets of health care facilities.

It is now time to discuss the philosophy of the health planning team. The two sacred cows of contemporary American life are the team concept and the planning program or cycle. Institutional programs are evaluated by management teams, educational efforts are delivered by teaching teams, and no endeavor may start without one or more planning cycles. Health planning teams seem to be arranged in an effort to elicit consensus and guarantee compromise. Many appointed individuals have little or no concept of the difficulties incurred in the deliverance of health care. Passively but democratically a few physicians and allied health personnel have been allowed to become members of the health planning team. As a result, the physician is being excluded from the main stream of the decision making process. We feel that everyone will lose because of this situation.

The neurosurgeons of the United States would like in some way to have a significant role in determining the future delivery of neurosurgical care in our country. At this time more than 2,500 members of the neurosurgical community have no assured voice at any stage in the health planning activities encompassed by the Health Planning and Resources Development Act. We sit on no national advisory boards for the planning of neurological surgery, we sit on no state health planning boards for the delivery of neurosurgical care. We are asked to participate as members of the democracy but are able to compete for only 1, 2 or perhaps 3 provider seats not allocated to special interest groups on Health Systems Agencies in our own area. These seats will give us no say in planning for the delivery of neurosurgical care. While we are so restricted, we observe local governing bodies exerting more leverage and requesting twenty-five per cent of the provider seats on governing boards of the Health Systems Agencies. We also observe governors demanding the power to gerrymander districts, approve and disapprove of Health Systems Agencies and their plans as well as encouraging state agencies to develop competing health plans. We observe the Secretary of Health, Education and Welfare having to review annually each Health Systems

Agency and comment upon its function, a chore almost impossible to do unless under contract with some corporation in the business of audit or review. In summary we are confronted with a situation in which it will be extremely difficult for individuals to make those contributions which in the past have allowed American technology and service to rapidly increase.

We urge that this Act be extended only on a year by year basis and that Congress initiate an intensive study of the present status of health planning and consider other planning methodologies than those of the Health Planning and Resources Development Act. Health planning based upon the recommendations of various specialties of medicine is one model deserving of consideration. In this way the neurological surgeons of the United States and their colleagues in other disciplines might step forward and submit plans to the government outlining the need for centers, equipment, and personnel. These plans could then be considered by the local Health Systems Agencies in the formulation of local plans. The local plans generated to date have been extremely bland. They have not really addressed any of the more social or poorly understood problems of health care which can not be solved by public members, no matter how conscientious

and hard working. Further, these problems will not be solved by government no matter how desirous the elected officials are of civic, social and health improvement. These problems will be solved only by dedicated professionals working within their own disciplines who will be able to place their reputations "on the line" in an effort to prove that their point of view or their accomplishments are in the best interest of society. Therefore, we urge Congress to create without delay, national planning panels in each recognized medical specialty as advisory subcommittees of the National Council of Health Planning and Development.

Mr. Chairman, thank you for inviting me here this day.

Louis A. Finney, M.D.

Charles Fager, M.D.

Russell Patterson, M.D.

Donald Stewart, M.D.

David Storrs, M.D.

for

Albert Rhoton, Jr., M.D.  
President, Congress of Neurological Surgeons

and

Charles Drake, M.D.  
President, American Association of Neurological Surgeons

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March 10, 1978

Bob Crane  
 Subcommittee on Health and  
 the Environment  
 House Committee on Interstate  
 and Foreign Commerce  
 House Annex Building - I  
 Room 702  
 Washington, D. C. 20515

Re: H.R. 10460: Proposed Amendments  
 to Section 1512(b)(3) of the  
 National Health Planning Act

Dear Bob:

After our telephone conversation yesterday, I reviewed my letter dated February 24, 1978 to the Congressional and Senate Subcommittees considering amendments to the National Health Planning Act, and particularly directed my attention to the argument made in the letter in the first three paragraphs of page three.

You are quite correct: the argument reflects a misconstruction of the statute. As a consequence, the argument attributes to the plaintiffs in the Texas Acorn and Rakestraw litigation a position which they in fact did not argue. The plaintiffs did not contend that the percentage of low income persons on the entire HSA board must conform to the demographic pattern of the community; they argued only that demographic conformity was required between the community and consumer portion of the HSA board.

Because my argument at page three is based on a misconstruction of the statute and a consequential misstatement of the plaintiffs' arguments, the illustration in the second paragraph of the letter is inapt.



Nevertheless, we continue to submit that the plaintiffs' insistence on conformity between the percentage of low income persons on the consumer portion of an HSA board and the community's demographic pattern is absurd and impractical. In many communities, HSA boards include a substantial number of politicians or local public officials. On some HSAs, the percentage of politicians or public officials serving as members of the consumer portion of the Board may be as high as 30 percent. Because these board members have a constituency which can insist on their accountability for planning decisions, their participation on the boards is highly desirable. Yet few of these persons will qualify as "low income" board members.

In the community hypothesized in my letter of February 24, the plaintiffs' demographic conformity argument would require that the consumer portion of the board consist of 65% low income persons and 30% politicians. Virtually all other interest groups would be effectively eliminated from the board, except to the extent that they were coincidentally represented by the politicians or the poor. Such a board could not be found "broadly representative" as required by the Act.

Please accept my apologies for the misstatement. In view of the subcommittee's action with respect to the bill, it would appear that none of the members of the subcommittee relied on the argument. Nevertheless, I regret the inaccuracy, and appreciate the fact that you called my attention to it.

If you deem it appropriate, please distribute copies of this letter to the House subcommittee members or to their staff personnel responsible for following this legislation. I am copying the Senate subcommittee members. Also, in view of my previous request that the February 24 letter be included as part of the record in this matter, I think that this correcting letter should also be included.

I look forward to discussing this legislation with you further. Best regards.

Sincerely,



A. Stephens Clay

STATEMENT OF THE  
AMERICAN PSYCHIATRIC ASSOCIATION  
ON THE RENEWAL OF  
THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974  
PUBLIC LAW 93-641

INTRODUCTION

The enactment of P.L. 93-641, based in great measure upon legislation introduced by you, Mr. Chairman, and co-sponsored by many subcommittee members, clearly marked a new era and holds much promise for the planning, development, and coordination of the nation's health care services and resources. Since its enactment, the American Psychiatric Association has carefully monitored its implementation, and served as advocates for active participation on behalf of the mentally ill.

The House Interstate and Foreign Commerce Committee report (House Report No. 93-1382) on the health planning legislation established clearly the legislative intent that health planning include activities such as mental health planning and that expertise in this area should be represented to the maximum extent possible. The report states: "Health planning in this context is understood by the Committee to include all of the broad range of planning activities which may contribute to improving the health of the people of the health service area including such activities as mental health planning ..."

The American Psychiatric Association agrees and believes that mental health should be viewed as a primary component of total health planning and service delivery and thus of central importance and focus to the development of health systems agencies, as well as the other organization elements

established under the legislation. Thus, it is vital that professionals, who as a result of their training, experience or attainments, are exceptionally well qualified in providing mental health treatment should be represented on the governing bodies of Health Systems Agencies, the Statewide Health Coordinating Councils, and the National Council on Health Planning and Development. It is also essential that staff with experience and capability in the field of mental health treatment and planning be an integral part of the total staff of each organizational element established by the legislation.

The field of mental health, broadly defined, includes the areas of emotional disturbance and stress, mental disabilities, substance abuse, and developmental disabilities. Since 1963, with the passage of the community mental health centers legislation, mental health systems at local, state, and national levels have concerned themselves with developing organized systems for health care delivery and planning which have been directed at the very objectives now articulated by the planning law, i.e., increased services to the underserved, development of primary prevention programs, improved availability and accessibility of services through consolidation of programs, expanded utilization and training of manpower, utilization review and cost containment, and the integral involvement of consumers in the planning and development of programs. Thus, the mental health system in the United States has a significant degree of experience in actually dealing with the issues keyed to the success of the planning law.

Implicit in the development of these mental health programs has been the attempt to approach the individual as well as the development of health care services in a holistic manner--which includes consideration of essential

environmental factors. Thus, mental health programs have been intimately involved and intertwined in the delivery of physical health services. It is estimated that from 15 to 50 percent of patients with an initial presumptive diagnosis of physical illness are, in fact, suffering from primary or secondary emotional problems. Therefore, the development of a mental health component generic to the delivery of all health services is an essential element of any health care delivery system. Studies conducted in organized group health programs (e.g., Group Health Association of Washington, D.C., Kaiser Plan of California, and Blue Cross of Western Pennsylvania) have proven the patient benefits as well as the positive cost benefits which can be achieved in incorporating a mental health orientation into the overall health planning and delivery process.

The field of mental health has taken steps to interface with human services such as education, social welfare and the juvenile court corrections system which provide vital opportunities for the early detection and intervention into situations which can lead to mental, physical and emotional disturbance. Such coordination places the mental health system in an advantageous position, enabling it to contribute significantly to the planning of health services and programs which are community-oriented, geared towards prevention and early intervention of disabilities, emphasize ambulatory care and deinstitutionalization, and have the capacity to provide services to the chronically ill.

For the foregoing reasons, we urge that there be mental health representation in the governance of each jurisdictional level called for under this legislation. Such representation on boards of governance must reflect the essential quality of mental health planning to the entire field of health

planning and service delivery. It must also be adequate and in proportion to the time, money, and experience invested in these mental health efforts.

Such staff representation must also reflect the unique contributions made to the planning process by both consumers and providers of mental health services. We note that H.R. 10553 as introduced amends the planning act to include representation on HSA governing bodies of either consumer or providers. (Emphasis supplied). We believe this is a restrictive amendment and, as noted in our attached amendments, would recommend that the "either-or" provision be amended to an inclusive "and". This will allow appropriate input by both providers and consumers of mental health care rather than establish a precedent in law which would tend to have concerned citizens—both "caring" mental health consumers and professionals—vying for inclusion.

Furthermore, staff with demonstrated capability and expertise in dealing with matters related to mental health planning should be available to these bodies. It is recommended that at least one staff person for each health service area be specially qualified through experience and training in the field of mental health planning and program development.

Despite the need for the development of a mental health component generic to the delivery of all health services, the physical and mental health care systems continue to develop in an uncoordinated and fragmented manner. Further, efforts to insure credible mental health representation and staffing have been continually frustrated.

In order to assure that the purposes and legislative intent of the health planning law are achieved, we recommend that the pending bill (H.R. 10460) be amended to incorporate the attached amendments to P.L. 93-641.

The APA recognizes that the Subcommittee has proposed amendments to



P.L. 93-641 within the Health Services Amendments of 1978 (H.R. 10553) and is pleased that an effort has been made to coordinate mental and other health planning. However, it is our belief that the best interests of those involved in health planning, those receiving the benefits of health planning, and the mental health planning and service delivery communities would be better served if the amendments bringing about full coordination of mental and physical health planning were made directly in the planning bill, per se (H.R. 10460), which will soon be considered by the Subcommittee in Executive Session.

We appreciate the opportunity to comment on this legislation, and hope we can work together to insure the best means of intertwining mental health planning with the body of health planning where it most clearly belongs.

PROPOSED AMENDMENTS TO PL 93-641

## Findings and Purpose (SEC. 2)

Section 2(a)(3)(B) of Public Law 93-641 is amended by deleting the "and" and inserting after Section 2(a)(3)(C) the following:

"(D) lack of effective coordination between the mental health care system and physical health care system, both by providers and planners, have promoted fragmentation, lack of continuity, and inappropriate utilization of the nation's health care resources; and

"(E) lack of attention to and emphasis on the behavioral aspects of physical health care and status."

## National Health Priorities (SEC. 1502)

Section 1502 is amended by adding the following new subsections at the end thereof:

"(11) The promotion of those health services which are provided in a manner cognizant of the emotional and psychological components of the prevention and treatment of illness and the maintenance of health.

"(12) The elimination of inappropriate placement in institutions of persons with mental health problems and the improvements of the quality of care provided those with mental health problems for whom institutional care is appropriate.

"(13) Assurances of access to community mental health centers and other mental health care providers for needed mental health services and emphasis on the provision of outpatient care as an alternative to inpatient mental health services, where appropriate."

## National Council on Health Planning and Development (SEC. 1503)

Section 1503(b)(1) is amended by adding after the second sentence the following:

"Such persons shall include professionals and consumers who are knowledgeable in the delivery of mental health services."

## Health Systems Agencies - Staff (SEC. 1512)

Section 1512(b)(2)(A)(iii) is amended by adding "and mental health" between "health" and "planning", and between "health" and "resources."

## Health Systems Agencies - Governing Body Composition (SEC. 1512)

(a) Section 1512(b)(3)(C)(i) is amended by adding "(including mental health)" after "consumers of health".

(b) Section 1512(b)(3)(C)(ii) is amended by adding "(including mental health)" after "providers of health".

(c) Section 1512(b)(3)(C)(iii) of the Public Health Service Act is amended by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively, and by adding after subclause (I) the following:

"(II) include (through consumer members and provider members) individuals who are knowledgeable in mental health planning and the delivery of mental health services."

#### Functions of Health Systems Agencies (SEC. 1513)

(a) Section 1513(b)(2) is amended by adding after the first sentence the following:

"The HSP of the agency shall include an identifiable mental health component. This component shall be developed under a procedure whereby the agency consults with persons, (acting as an advisory group, task force or other entity appointed by the agency) knowledgeable and experienced in mental health planning and the delivery of such services, who will have the opportunity to make recommendations to the agency regarding such component. To the extent practicable, the composition of such advisory group, task force or entity, shall conform to the requirements of Section 1512(b)(3)(C) and shall include representatives of local and regional mental health planning agencies, groups and appropriate entities otherwise established pursuant to law."

(b) Section 1513(d)(3) is amended by inserting "(including local and regional mental health planning agencies, groups and appropriate entities otherwise established pursuant to law)" after the word "agencies".

(c) Section 1513(e)(A) is amended by adding at the end thereof the following:

"provided, however, that where a catchment area established under the Community Mental Health Centers Act is subject to the jurisdiction of more than one health systems agency, that catchment area shall be subject to the jurisdiction of only one such health systems agency pursuant to regulations prescribed by the Secretary."

#### State Health Planning and Development Functions (SEC. 1523)

(a) Section 1523(a)(2) is amended as follows:

"(2) Prepare, review and revise as necessary (but at least annually) a preliminary State health plan which shall be comprised of the HSPs of the Health Systems Agencies within the State. In carrying out its functions under the prededing with respect to the mental health component of the preliminary State Health Plan, the State Agency shall refer the mental health components of such HSPs to the State mental health authority, designated by the Governor, to review such components, which will review such components and prepare the mental health component of the preliminary State health plan. The mental health component of such preliminary plan may, as found necessary by the State mental health authority, contain such revisions of the mental health components of such HSPs to achieve their appropriate coordination or to deal more effectively with statewide mental health needs. The remainder of such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSPs to achieve their appropriate coordination or to deal more effectively with statewide health needs. The preliminary State health plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan under Section 1524(c)."

(b) Section 1524(b)(1)(i) is amended by inserting "(which shall include at least one person who is knowledgeable in the delivery of mental health services)" between "nominees" and "submitted".

#### Statewide Health Coordinating Council (SEC. 1524)

Section 1524(c)(2) is amended by adding at the end thereof:

"(C) In carrying out its functions with respect to the mental health component of the State health plan, the SHCC shall follow a procedure under which the State advisory council designated in subparagraph (D) of this section will have the opportunity to make recommendations to the SHCC respecting such component.

"(D) The State mental health authority, designated by the Governor, shall implement those parts of the State health plan which relate to the government of the State. The Governor shall designate a State mental health advisory council to advise the State mental health authority in carrying out its functions under this subparagraph and Section 1523(a)(2). The membership of the State mental health advisory council shall include (i) representatives of nongovernment organizations or groups, and of State agencies, concerned with the planning, operation, or use of community mental health centers and other mental health facilities, (ii) representatives of consumers and providers of the services of such facilities who are familiar with the need of such services, (iii) representatives of mental health advisory groups established under Section 1513, and (iv) representatives of local/regional mental health planning agencies or entities otherwise established pursuant to law. Those persons designated under clause (iii) shall constitute a majority (but not more than sixty per centum) of the Council's membership.

#### Grants for State Health Planning and Development (SEC. 1525)

Section 1525(a) is amended by inserting "and the State mental health authority designated under subsection Section 1523(a)(2)" after "Section 1521".

## Statement of

The American Society of Internal Medicine  
on the  
HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1978, HR 10460

presented to the  
Subcommittee on Health and the Environment,  
House Interstate and Foreign Commerce Committee

February 1978

The American Society of Internal Medicine (ASIM) is a federation of 51 state component societies of internal medicine, representing more than 15,000 members who, by training and practice standards, are recognized as specialists in internal medicine. ASIM has expended considerable time and resources since January 1975 in support of local implementation of Public Law 93-641. We distributed to every HSA comments and policy positions on the ten National Health Priorities. The Society has repeatedly urged internists to become involved in their HSAs by offering to serve on the governing bodies or their advisory groups. ASIM has also reviewed and submitted comments on several sets of proposed rules and five monographs developed to provide technical assistance to HSAs. We therefore have a strong interest in making local health planning effective. While we support many of the provisions in HR 10460, we are also concerned about many. These comments address those which are of most concern.

Physician Participation in Health Planning

Section 209 of HR 10460 contains several amendments to clarify the required composition of HSA governing bodies. None of these, however, addresses what we believe to be the major problem--the restrictions placed on "providers" that discourage participation by practicing physicians.

ASIM understands the need for broad representation on governing bodies with a majority of "consumers." However, we believe the classifications and unfair



restrictions within the broad provider category discourage those most knowledgeable about the realities of medical care from participating in the health planning process.

ASIM believes that the input of practicing physicians is crucial to effective local planning. Because of their medical expertise and their position as the focal point of medical care delivery, physicians possess an important perspective no one else can provide. It has recently been suggested that physicians make the decision on 85 percent of all medical care expenditures. Yet, under current law, physicians are not even guaranteed a position on HSA governing bodies and their chances for appointment are limited as a result of the bogus classification "indirect providers."

We recommend that the indirect provider classification be deleted. It restricts the participation of other provider groups such as hospitals, health insurers, dentists, nurses, and other allied health professionals. All of these can make substantial contributions to effective health planning. As many of these groups as possible should be represented at the governing body level. The indirect provider classification serves to restrict and discourage their participation.

In 1976 the ASIM House of Delegates passed a resolution calling for no less than 15 percent practicing physician participation on each HSA governing body. We recommend that the law be amended to provide specifically for practicing physician representation on HSAs and Statewide Health Coordinating Councils and the National Council on Health Planning and Development as well.

#### Extension of Certificate of Need

Under Section 218, Certificate of Need (CON) would be extended to cover purchases of equipment costing more than \$150,000 for physicians' offices. We strongly object to this provision. We believe this step is, at best, premature; it could

serve as a serious obstacle to providing services in the ambulatory setting that are now provided at greater cost in the institutional setting.

The cost effectiveness of existing programs is yet to be proven. CON is an administratively expensive and cumbersome process for both the certificate applicant and the State Agency. Administering a program for new institutional services alone is a monumental task. To extend CON to the ambulatory setting in light of its uncertain effectiveness seems unwarranted.

One of the objectives of ASIM is to advance and promote ambulatory care. It has been established that many services previously provided only in institutions can now be offered in the ambulatory setting at a lesser cost without compromising quality. We must continue to seek ways to shift more services to the ambulatory setting. However, many diagnostic procedures and treatment modalities involve expensive equipment that will require a CON. It will unquestionably be more difficult for physicians' offices to prepare CON applications than for hospitals. And the fact that CON inherently stifles competition will tend to "give the franchise" to existing services in hospitals. This will remove incentives for cost-saving innovations in ambulatory care.

Until the cost effectiveness of CON is proven and its potential effects on ambulatory care carefully examined, we recommend that it not be extended to cover physicians' offices.

Section 218 appears to exempt institutional health services provided by or through Health Maintenance Organizations (HMOs) from CON. If this interpretation is correct, we strongly oppose this provision. The purpose of CON is to assure that new institutional health services are needed. Allowing any exemption defeats the purpose. We recommend that this provision be amended so that CON applies equally to all institutional health services.

Decertification of Health Facilities

Section 219 would require HSAs and State Agencies, within four years of enactment of HR 10460, to institute a program to decertify health services determined to be inappropriate. The Secretary of DHEW would be empowered to determine what services and on what basis they would be decertified. In essence this provision would legislate federal authority to close existing facilities, and this is what generated most of the objections to the first set of proposed National Health Planning Guidelines. The provision presupposes that the Secretary of DHEW can better determine what services are needed in a community than the people in the community. Yet during the debate over the proposed Guidelines, hundreds of examples were cited where federally determined standards would force the closing of needed facilities.

Since four years is allowed before the decertification program would take effect, we see no reason to legislate it now. This time should be used instead to evaluate the effects of the Guidelines for approving new services and to experiment with a voluntary approach to phasing out unneeded services based on incentives similar to that proposed in S 2410.

We recommend that Section 219 be deleted.

Conclusion: Diminishing Local Control

The original intent of PL 93-641 was to provide a mechanism for local health planning. However, as implementation of the law progresses, more and more authority is given to or usurped by the federal and state governments, generally at the expense of HSAs. This pattern has been established in regulations promulgated by the Secretary, with the National Health Planning Guidelines as the prime example. Now HR 10460 proposes to broaden the Secretary's authority and to give additional powers to State Governors and State Agencies.

We find this an alarming trend. As indicated by the reaction to the Guidelines, the public does not want this to happen to the planning process and we hope Congress will halt subversion of local control. It seems that these shifts in power result from efforts to address isolated problems. When viewed individually, they appear relatively harmless. However, we must step back and consider their cumulative effects. Now is the time to do so, before it is too late and local planning has been emasculated.

Planning to meet local needs can be done effectively only at the local level. We urge Congress to assure that HSAs have authority for that planning and are given full opportunity to make it work. If the erosion of local control is allowed to continue, we are fearful that Public Law 93-641 will fail to fulfill its purposes.

STATEMENT  
on  
HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS (H.R. 10460)  
for submission to the  
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT  
of the  
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE  
for the  
CHAMBER OF COMMERCE OF THE UNITED STATES  
by  
JAN PETER OZGA\*  
February 13, 1978

The Chamber of Commerce of the United States welcomes this opportunity to present its views on the "Health Planning and Resources Development Amendments" (H.R. 10460). Our membership of more than 71,000 business firms, trade and professional associations, and state and local chambers of commerce is deeply committed to improving the Nation's health planning capabilities. Our support is based on the conviction that local health planning represents one of the best ways to control rising health costs.

In general, we believe that H.R. 10460 is a step in the right direction in coordinating the existing authority for local, state and national health planning. With some minor changes, we support the passage of this bill.

#### BUSINESS AND HEALTH

Business' interest in health care is underscored by the fact that it is the largest private purchaser of health care in the United States. Last year business invested about \$60 billion in health care.

This figure includes some \$33 billion spent by employers on group health insurance for employees and their dependents and workers' compensation medical benefits.

Over the last quarter century employer contributions for health-related benefits have risen such that now 80 percent of all private health insurance is bought through the workplace. About 70 percent of this insurance is paid

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\* Associate Director, Health Care, Chamber of Commerce of the United States



by employers. In 40 percent of the cases, employers pay for the entire cost of health insurance. In only 10 percent of the cases is the employee required to pay the entire bill. This is the reverse of the situation about 25 years ago.

Although wages increased about 85 percent between 1965 and 1975, health-related benefits rose nearly 200 percent during the same time period. Health benefits now represent about six percent of employee costs.

Business spends another \$27 billion on taxes for public health programs (e.g. Medicare, Medicaid), company-sponsored health programs (e.g. drug abuse treatment, mental health counseling and physical fitness projects) and corporate philanthropy.

All told, business pays for about 40 percent of the Nation's \$160 billion health bill. Clearly, business has a major stake in American health care.

#### BUSINESS AND HEALTH PLANNING

Business people are involved in the health planning process at all levels throughout the Nation. Ohio, in particular, is a showcase for the value of having management officials on health planning boards. For example, the Summit-Portage County Health Systems Agency between August 1974 and February 1977 was responsible for the denial or withdrawal of nearly \$80 million in unnecessary health projects. Significantly, the president of the local health systems agency is Richard M. Martin, Manager of Health Services Industry Relations for Goodyear Tire and Rubber Company in Akron. Mr. Martin also is an active member of the National Chamber's Special Committee on the Nation's Health Care Needs.

Within the same state, the Central Ohio River Valley Association for Health Planning and Resource Development (CORVA) has been responsible for saving its area some \$60 million in unneeded health investments since 1974. Last year alone, CORVA cut \$8.5 million in proposed hospital spending. CORVA's current president, James F. Sandman, ascribes the agency's success to several major industries in the area including Proctor and Gamble, Kroger Stores, and Cincinnati Milacron. CORVA's past president is John Bullock,

Senior Vice President, First National Bank of Cincinnati. He is also Chairman of the Health Care Committee of the Greater Cincinnati Chamber of Commerce.

CORVA was the first designated health systems agency under provisions of the new health planning law (P.L. 93-641). The Cincinnati Chamber played a major role in helping CORVA become so designated and involving business people in the health planning process, even as early as the mid-1960's.

Ohio is not alone in having responsible input and leadership in health planning from the business community. The Middle Tennessee Health Systems Agency (serving Nashville and environs) has also been responsible for a number of astute planning decisions saving the community millions of dollars in questionable health projects. John L. Brown, Corporate Director of Employee Benefits for Genesco, Inc., serves as Vice Chairman of the Project Review Committee for the Middle Tennessee Health Systems Agency.

In addition, Lachlan L. Lyatt, Executive Vice President of Butte Knitting Mills, serves as a member of the County Health Planning Commission in Spartanburg, South Carolina. And, Richard G. Wardrop, Manager, Employee Benefits Program, Aluminum Company of America, is a member of the Legislative Issues Committee for the health systems agency of Southwest Pennsylvania.

Finally, it must be mentioned that the current president of the American Health Planning Association, which represents most of the 200-plus health systems agencies, is Bernardo Benes, a prominent banker in the Miami, Florida area. There are, of course, hundreds of other example of business participation in health care. It appears that where business is represented on health planning boards there is more stringent review of health projects and generally the health care system is improved as a result.

The CORVA experience has been documented in an article which appeared in the October 31, 1977 issue of Business Week. CORVA and other agencies and business people mentioned above also are described in "Health and Industry," proceedings from a recent conference on business and health planning, sponsored partly by Genesco. The specific role that the Cincinnati Chamber of Commerce played in the development and implementation of CORVA is highlighted in this publication.

## CHAMBER POSITION ON H.R. 10460

We will address several major provisions of H.R. 10460:

Governing Board Members

The National Chamber supports H.R. 10460's provision to require that the selection process for membership on health planning boards should be made public. Also, at least one person representing business should be on all health planning boards. We also support the continuing education of these board members. To the extent possible, existing resources, such as the National Health Planning Information Center and Regional Health Planning Centers, should be used for this purpose.

State Planning Authorities

The National Chamber opposes H.R. 10460's provision to increase state authority in the planning process. State planning bodies, bowing to organized pressure, have in several instances reversed decisions by local planning groups, which would have saved the community unnecessary capital investment. There should be local solutions to local problems. Moreover, these decisions should come from private sources; thus, we favor limiting the number of public officials on planning boards.

Data Collection and Coordination

The National Chamber supports H.R. 10460's provision to improve the linkage between local and state health planning in so far as it will improve local health planning. Data gathered and analyzed by the Department of Health, Education and Welfare from these sources should avert the problems associated with the National Health Planning Guidelines issued in September 1977. Hospital bed-to-population ratios in these controversial proposed rules were intended to be a guide. However, because of their perceived rigidity, it appeared that their effect would be to close many hospitals located in rural areas. We hope, also, that the amendments to H.R. 10460 will avoid this confusion in the future. Also, data collection should be coordinated with Professional Standard Review Organizations and other programs with similar activities.

Capital Investment

All health care institutions in any area have a responsibility to help meet that community's health care needs without wasteful duplication of facilities and needless expenditure of funds. They should be required to make available their budgets, financial statements and scale of rates to private and public payers. All hospitals, extended care and nursing home facilities should accept overall decisions by area-wide planning councils, or be subject to penalties.

We also favor a project review process which recognizes the cost-effectiveness of health maintenance organizations (HMOs) and other alternative forms of health care delivery. Further, the planning process should address all health facilities, public and private.

However, the National Chamber opposes attempts to place an arbitrary national limit on capital investment and require health systems agencies to enforce these limits. Such national limits do not take into account those communities which might require more or less investment to accommodate local needs.

We support H.R. 10460's providing incentives to hospitals to modify their operation to reflect the changing health needs of their communities. For example, the closing or converting of unused beds for other uses should be encouraged, so that there is appropriate use of health facilities.

Health Planning Efficiency

Health care planning councils should be adequately staffed with competent personnel so they can operate efficiently. We support H.R. 10460's section allowing the funding formula for local health planning bodies to be based on the needs of the area and the financial needs of the local health systems agency.

## SUMMARY

The National Chamber has long supported the concept of local health planning especially as it incorporates input from business people. Indeed, our advocacy for a "Council on Health Advisors" precedes by several years the actual formation of the National Health Planning Council, created by P.L. 93-641.

Because of this relatively long-standing support for health planning -- especially at the local level -- the National Chamber supports the passage of H.R. 10460, with these reservations: state health planning authorities should not overrule decisions made at the local level; the number of public officials serving on health planning boards should be limited; and, the level of capital investment should be determined locally.

Under the present law, health planning is a relatively new process. Business has played an active part in health planning but recognizes that changes are needed to improve the process. H.R. 10460 should help in this regard, and the National Chamber supports its passage.



STATEMENT OF  
HOSPITAL ASSOCIATION OF NEW YORK STATE

INTRODUCTION

This testimony is submitted by the Hospital Association of New York State on behalf of its members, 300 voluntary and public not-for-profit hospitals and health care institutions. These institutions represent about 90% of the general, acute care hospital admissions in New York State, and approximately 10% of those for the entire United States.

The Hospital Association of New York State has supported implementation of P.L.93-641, as indicated by the January 1977 letter from our Board Chairman to member hospitals urging an orderly but expeditious shrinkage of the hospital delivery system (enclosure I). We also support and congratulate you on the amendments to the planning law contained in H.R.10460. The comments and recommendations in the following testimony will serve to make a good bill better.

But first, we have noted below the provisions of this bill which we feel are particularly good:

Section 208's provision allowing HSAs to accept financial support from insurers;

Sections 213 and 215 requiring HSAs to have a program of training and education for board and executive committee members;

Section 218's revised CON program (except as noted below);

Section 224's increased minimum grants to HSAs and increased overall authorizations for HSAs and state agencies;

Section 301's program for assistance to public hospitals, except that it should be expanded to include private, not-for-profit institutions.

In our testimony we first describe health planning problems of a general nature which are not addressed at all or which we believe should be further addressed in H.R.10460. Following those initial comments, we make recommendations on specific sections of H.R.10460 which we believe should be redrafted.

#### General Problems with the Health Planning System

##### Clarification between National Goals and Standards, and Local Health Systems Plans

In the supplementary information section of the proposed National Health Planning Guidelines issued on September 23, 1977, was a strong statement by HEW Secretary Califano that National Health Planning Guidelines included under P.L.93-641 were required to be utilized as minimum goals and standards in local health systems plans. While that statement was modified significantly by the January 20, 1978 proposed guidelines, it still must be emphasized that the nature of the planning process requires it to begin at the local level and allow for substantial variability in local conditions and needs.

Therefore, we recommend that section 153(b)(2) subsection C of the Public Health Service Act be changed to state that Health Systems Agencies should "take into account" the National Guidelines for Health Planning Policy issued by the Secretary

under Section 1501 rather than "be consistent with" those national guidelines.

#### Role of the State in the Health Planning Structure

H.R.10460 seeks to greatly increase the Governor's role in the health planning process. The Governor will have the authority to select the chairman of the Statewide Health Coordinating Council under this legislation. Through the SHPDA, he will also assume the authority to "determine, after consultation with the Statewide Health Coordinating Council, the health needs of the State which are statewide." Through this mechanism the Governor will have veto authority over the State Health Plan.

Another way the Governor's role is increased is by the Secretary giving priority to HSA's requests for conditional designation if they have the recommendation of the Governor. The Governor will then be notified when the Secretary enters into an agreement under which the HSA will be given conditional status.

We find this increase in the power of the Governor to be a step backward for the health planning process. As established by P.L.93-641, the planning process was intended to be separate from the political process in order to ensure that statewide fiscal and political considerations do not unduly interfere with the adequate supply or distribution of health care resources. In New York, state budget problems have already imposed heavily on hospitals. Increases in Medicaid and Blue Cross hospital inpatient reimbursement rates has been tightly controlled by

the State. For the last three years, Medicaid rates have increased a total of 3 percent. Medicaid outpatient rates are still frozen at the 1975 level. These oppressive measures have been taken not because of a lack of need or justification on the part of hospitals, but because of New York City and State budgetary problems. As the Governor is granted increased control over the planning process, these same budgetary considerations may take precedence over development of a planning process responsive to the health care needs of our citizens.

Therefore, we recommend that the health planning process be kept independent of the state government as prescribed by P.L.93-641 and those amendments giving the Governor increased authority to control the planning process be deleted. However, the provisions providing the Governor with authority to submit comments and recommendations to HEW concerning HSA approval and SHP approval are necessary for due process and should therefore be retained in H.R.10460.

#### Project Review Schedules

Under Section 1122 of the Social Security Act, project reviews must be completed within 90 days after complete information concerning the project has been submitted. If those reviews are not completed within the 90 day limit, the project is deemed to have been approved by the designated planning agency. The effect of this 90 day limit has been to force the reviewing agencies to rule expeditiously on applications and to provide written explanations for negative decisions.

However, when the designated State Agency reviews an institutional request under Certificate of Need, the project is deemed unneeded if no decision is reached within the period of time specified for State Agency review. In New York State project reviews are often not completed expeditiously, resulting in costly delays and a great deal of confusion.

Therefore, we recommend that the effected party in all CON reviews be given written notification of the beginning of a review. If the designated State Agency then fails to act upon the project within 90 days, the project should be deemed approved.

#### Hospital Construction Requirements

The Hospital Association of New York State recently completed a study indicating that there are over 164 federal, state, local and voluntary agencies involved in regulating hospitals. Federal agencies such as Medicare and the FHA often impose compliance with construction standards as a condition for participation in their programs; state agencies regulate through certification or licensure laws; and local authorities enforce building and sanitation codes. Because of a tremendous lack of communication and coordination, the standards imposed by these different levels of government are often in conflict with each other.

Beyond the obvious confusion and conflicts caused by these overlapping rules and regulations, in an industry which is having its costs reviewed microscopically this duplication is an extremely expensive problem. It is our belief that the federal



government must take the lead in resolving the situation.

Therefore, we recommend that all federal programs which include codes and standards for physical facilities as conditions for participation be required to have consistent or identical standards. Further, state and local authorities and voluntary accreditation or certification bodies should be urged to adopt the federal standards as their own. State and local authorities should then be authorized to impose additional, but not conflicting, requirements or waivers to accommodate unusual weather, geological conditions, or other hazards.

#### Section-by-Section Recommendations on H.R.10460

##### Funds for Health Systems Agencies (Section 208)

One limiting factor in the present planning process is the budgetary constraints under which Health Systems Agencies now operate. Therefore, in addition to the increase in grant funds you have proposed in H.R.10460, we recommend that the sources of non-federal funds which can be used by HSA's for accomplishing their goals be notified to authorize a broader base of private and public contributions. We also believe that the contributions from private sources to an HSA should be limited to 25% of its aggregate operating budget, and that a Health Systems Agency should be authorized to accept 10% of its operating budget, but not more than \$25,000, in contributions (other than processed data) from any individual or private entity. This would allow HSAs to receive additional matching federal funds and also broaden the scope of non-federal funds that can be used without

jeopardizing the Health Systems Agency's actions.

Further, we recommend H.R.10460 be amended to encourage state funding for activities undertaken by HSAs at the request of the state. Such activities are generally relevant to federally mandated functions carried out by the HSA, but are beyond the scope of federal funding.

Composition of Health Systems Agencies Governing Bodies (Section 209)

Section 2 of P.L.93-641 states that the health care provider is one of the most important participants in any health care delivery system. It further says that health policy must address the legitimate needs and concerns of the provider and that the provider must therefore be encouraged to play an active role in developing health policy at all levels.

However, in Section 1512 of the Planning Law, there is no delineation of how providers are to be represented on the governing boards of HSA's. Further, there is no requirement that hospitals be represented (if at all) by persons directly involved in hospital administration. We believe that only those involved on a daily basis with hospital administration can adequately understand the problems being faced by hospitals and, therefore, only they can properly represent hospitals on HSA governing boards.

Therefore, we recommend that at least one member of the HSA governing board for each HSA be a representative of hospital administration.

Included in the Planning Law's definition of "indirect providers" are persons who are nonproviders with only coincidental or indirect ties to the health system and some who have direct conflicts with providers. We feel that this is a grave injustice and that these persons and organizations should only serve as consumer representatives for they do not in any way represent a provider prospective.

Therefore, we recommend that the definition of "indirect provider" not include, 1) insurers who do not provide health services to the public, either directly or through affiliates or subsidiaries, 2) any individual who receives less than one-quarter of his gross income from health care interest or direct providers, 3) organizations which are basically concerned with education and research in aspects of particular diseases, 4) members of the immediate family or an indirect provider, or 5) consumer representatives who serve on provider governing boards.

#### Certificate of Need Program (Section 218)

We believe that all providers of health services should be subject to review by HSA's and approval by state Certificate of Need Agencies. We would except from this provision all private offices of health practitioners for the purchase of all equipment under \$150,000.

Although expensive medical equipment, such as CAT Scanners, are included under CON review for private and public hospitals in New York State, they are still proliferating because of their

purchase by physicians or other health care providers not subject to HSA review and Certificate of Need approval.

Since it is a goal of the health planning system to prevent the over-development of new or altered services and facilities, we recommend that, with the exception of physician's offices mentioned above, all health care providers including HMOs, ambulatory surgery centers and extended care facilities be subject to HSA and Certificate of Need review.

We also recommend revising Section 218(b)(4) which allows batching of CON requests. Batching may be an acceptable method of evaluating these requests, but the one-year delay which could result is unreasonable.

The Composition of Statewide Health Coordinating Councils (Section 223)

There is no assurance in P.L.93-641 that hospital providers will be represented adequately at the state level of the planning process. Hospitals are now being represented by individuals not directly involved in the health care delivery system and therefore not necessarily well appraised of the current problems being faced by hospitals and not having an adequate understanding of the needs of hospitals.

In order to help ensure proper representation of the hospital point of view on State Health Planning Agencies, we recommend that not less than three-quarters of the providers of health care who are members of a SHCC be direct providers of health care.

We also recommend that at least one of these providers be a representative of hospital administration.

Provision of Free Care (Section 302)

Hospitals receiving funds under Section 1601 of the Public Health Service Act are required to provide free care "at all times" after approval of an application for a funding grant. When financially feasible in any way, hospitals now provide and will continue to provide free care to those individuals unable to pay. To be accountable for that free care for an undetermined and seemingly unending period of time we believe is contrary to good public policy.

Therefore, we recommend that for a period of 20 years after the approval of their funding applications (in the case of a grant), or the length of time of the loan or loan guarantee, facilities receiving allotments, loans, loan guarantees or interest subsidies under Section 1601 be required to make health care available to patients who are unable to pay.

Summary of Recommendations

We recommend that:

1. Section 1513(b)(2) subsection C of the Public Health Service Act be changed to state that Health Systems Agencies should "take into account" the National Guidelines for Health Planning Policy issued by the Secretary under Section 1501, rather than "be consistent with" those national guidelines.



2. The health planning process be kept independent of the state government and those amendments to H.R.10460 giving the Governor increased authority to control the health planning process be deleted.
3. The effected party in all CON reviews be given written notification of the beginning of a review and if the designated state agency then fails to act upon the project within 90 days, the project be deemed approved.
4. All federal programs which include codes and standards for physical facilities as conditions for participation be required to have consistent or identical standards.
5. The sources of non-federal funds which can be used by HSAs for accomplishing their goals be modified to authorize a broader base of private and public contributions. We also recommend that H.R.10460 be amended to encourage state funding for activities undertaken by HSAs at the request of the state.
6. At least one member of the HSA governing board for each HSA be a representative of hospital administration.
7. The definition of "indirect providers" be narrowed to exclude persons who are non-providers with only coincidental or indirect ties to the health system.

8. All health care providers, including HMOs, ambulatory surgery centers and extended care facilities be subject to HSA and Certificate of Need review. This should not apply to health practitioners' private offices for the purchase of all equipment under \$150,000.
9. Section 218(b)(4) which allows batching of CON requests be revised. Batching may be an acceptable method of evaluating those requests, but the one-year delay which could result is unreasonable.
10. Not less than three-quarters of the practitioners of health care who are members of a SHCC should be direct providers of health care. We also recommend that at least one of these providers be representative of hospital administration.
11. For a period of 20 years after the approval of their funding applications (in the case of a grant), or the length of time of a loan or loan guarantee, facilities receiving allotments, loans, loan guarantees or interest subsidies under Section 1601 be required to make health care available to patients who are unable to pay.

#### CONCLUSION

The Hospital Association of New York State will continue to actively support the implementation of the National Health Planning and Resources Development Act of 1974. We would be pleased to provide any assistance which you or your staff may require in amending this legislation to improve the health planning process.



# Hospital Association of New York State

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January 10, 1977

Dear Colleague:

The finite fiscal resources of the State have resulted in chronic underfunding of our existing hospital system. After careful study of the options available, the Hospital Association is convinced that in order to maintain quality in light of the current fiscal realities, a shrinkage of our hospital system is necessary. Through such a shrinkage our limited funds can more effectively be utilized to produce the best patient care possible.

There are a variety of measures, including closures, mergers, regionalization and expansion of alternate services, which can realize a reduction in the number of acute care beds. Hospitals, through their administrators, trustees and medical staff must participate fully in this process. To assure that these vital decisions concerning system changes are equitable and effective, professional planning must be utilized and due process must be afforded to both institutions and the public.

To achieve a rational system and preserve the excellent quality of New York health care, the Association makes the following recommendations:

1. The Department of Health in coordination with the HSA's immediately develop a proposal for an appropriate delivery system of health care services throughout the State.
2. Each health care facility in the State give the highest priority to participation and cooperation with the above mentioned proposal and immediately investigate the appropriateness and possibilities for:
  - a) complete or partial closure of their facility,
  - b) mergers with other facilities,
  - c) conversion to alternate services of health facilities,
  - d) elimination of duplicate services.

3. All previously approved acute care bed construction be re-evaluated unless construction has commenced.
4. The HSA's and government take an active role in recognizing and acting upon the need for additional beds and services in areas where needs exist, and continue to encourage correction of obsolescence.
5. All costs attendant to the above proposals must be paid for over and above the normal reimbursement formulae.

The Association recognizes that these changes will be exceedingly difficult. Survival, however, of a quality hospital system demands commitment to the totality by all of its parts.

I urge that each of you actively participate in this process.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Irvin G. Wilmot', with a large, stylized initial 'I'.

Irvin G. Wilmot  
Chairman

cc: Personal Members



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STATEMENT OF JOHN F. HORTY, PRESIDENT,  
NATIONAL COUNCIL OF COMMUNITY HOSPITALS,  
TO THE SUBCOMMITTEE ON HEALTH AND  
ENVIRONMENT OF THE COMMITTEE ON  
INTERSTATE AND FOREIGN COMMERCE  
ON H. R. 10460  
FEBRUARY, 1978





STATEMENT OF JOHN F. HORTY, PRESIDENT,  
NATIONAL COUNCIL OF COMMUNITY HOSPITALS,  
TO THE SUBCOMMITTEE ON HEALTH AND  
ENVIRONMENT OF THE COMMITTEE ON  
INTERSTATE AND FOREIGN COMMERCE  
ON H. R. 10460  
FEBRUARY, 1978

My name is John F. Horthy. I am President of the National Council of Community Hospitals, which represents the community hospitals of this country. NCCH members represent a broad spectrum of hospitals in every section of this country and of every size. Collectively, they provide more than 27,000 acute care hospital beds.

I am pleased to be able to testify on H. R. 10460. This Bill would make needed technical amendments to the National Health Planning and Resources Development Act of 1974. Most importantly, it focuses for the first time on some of the major issues that are developing under the Planning Act. Your staff has performed prodigious feats in considering some of the deficiencies of that intricate Act. We believe a number of additional amendments and deletions are necessary at this time to improve the operation of the Planning Act, to make it more equitable, and to better reflect what we understand to be the intent of this Committee and of Congress.

I would like, however, to express my disappointment at the narrow scope in which amendments to the Planning Act are being considered. Although at one time health planning may have been

**NATIONAL COUNCIL OF  
COMMUNITY HOSPITALS**

assumed automatically to be a good thing, this is no longer true. In no other sector of American society does the public believe it advisable or possible to have the Government "plan" who shall provide what services where and when. We seriously doubt it is possible realistically to plan the health care delivery system in the way assumed by the Act. There are no "right" answers as to how many beds there should be per thousand or how many CT scanners there should be or who should have them. Planning by its very nature promotes rigidity. Current orthodoxy will be encouraged; the creative urge of thousands of people trying other solutions will be submerged.

Even if the planning process were operated in a totally independent manner, the decisions it would make would not infrequently be arbitrary, unfair, and just plain wrong. Could planning, for instance, have anticipated the downturn in the birth rate? Is planning going to close beds on the basis of that downturn when indeed there are indications now that the birth rate has not in fact declined, but been stretched out?

In addition, the planning process formulated by the Planning Act is largely political, rather than cooperative; centralized, rather than local. The final planning decisions are made by the SHPDA and the SHCC, both of which are to various degrees controlled and appointed by the Governor. Further, HEW reserves for itself the power to determine whether or not the planning agencies are doing a job that

satisfies it and thus has the ultimate authority over the planning process.

Although this Committee and Congress, as we understand, intend planning decisions to be made locally, the process actually works otherwise: the Planning Act confers only advisory authority on the HSA's; the States make the actual decision; and HEW has a club to ensure that the decisions are acceptable to it. It is thus inevitable that major planning decisions will be made on a political basis and far from the locality where their impact will be felt. We seriously question if that is the proper way to allocate health care resources. Such a process may result in the protection and enhancement of "establishment" health care institutions who can have more political influence on the state level. It will intrude HEW, the State, and eventually even Congress into demands by every sort of special interest health care consumer. It will interject numerous political factors, unrelated to health care needs, into the decision.

We would, therefore, have preferred to see the debate focused on whether planning is a proper subject of Federal legislation in the first place. NCCH well understands the importance of the problems the Planning Act is intended to address. However, that Act is constructed on principles and assumptions that are philosophically bankrupt. The problems the Act wishes to address can be resolved, if at all, only by making fundamental reforms in the health care delivery system. We do not believe that adding mandated planning to the existing system is any

substitute for the basic new approaches that are needed. We believe that it would be preferable if instead of tinkering with the Planning Act, Congress undertook a more fundamental reevaluation of the premises upon which the Federal Government approaches the health care field and considered whether there are not other mechanisms that would more efficiently and with less heavy-handed regulation make the system more responsive to the desires and needs of the American public. For this reason, in my testimony of May 12, 1977, NCCH set forth its own cost containment proposal which was designed to force an evaluation by the American public generally and by the Congress specifically of what the American people want from their health care delivery system and how they want it structured.

However, given the fact that the debate is going to focus on what adjustments should be made to the existing planning apparatus, I will concentrate my testimony on those issues, for we believe a number of changes should be made now if the Planning Act is to be extended.

1. Planning agencies should not have the power to close existing facilities or services.

In its present form the Planning Act does not require states to institute planning programs that provide for closing existing facilities or terminating health services currently offered. We believe Congress' earlier decision not to apply current planning notions retroactively to existing facilities

and services is the only equitable and proper one. We are, therefore, concerned by provisions included in H. R. 10460 which apparently are intended to require the States to close existing facilities and services that are deemed "inappropriate" and to subject existing services to certificate-of-need requirements.

I refer first to Section 219(b) of the Bill, which would add language after Section 1523(a)(6) requiring the states to have a program "which provides that institutional and home health services found to be inappropriate under a review conducted under paragraph (6) may not be provided in such State."

We strongly oppose this effort to require the states to grant their planning agencies the authority to terminate existing services.

It is not clear whether Section 219(b) would require the termination only of services, and not facilities as well, but the distinction is as a practical matter unimportant. If a hospital is unable to provide a service, it will be unable to use related items of equipment, and if there is no other service for which a building can be used (and which is approved by the planning agencies), it will be required to close a facility or part of a facility.\*

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\*/ The fact that the proposed new provision would apply to facilities as well as services is further demonstrated by Section 202 of the Bill, which would add to the national health priorities "the discontinuance of duplicative or



However interpreted, this provision would be totally unfair. Closing a service would reduce a hospital's revenues, but the hospital would still be required to repay whatever indebtedness may have been incurred to finance that service or facility. The authority to order that services be discontinued would give the planning agencies the power of life and death over every health care institution. As contemplated by the proposed amendment, the planning agencies could simply determine that the acute care services provided by a particular hospital are no longer appropriate and that hospital could well be required to close.

Such a proposal highlights the abuses inherent in the planning process. We do not believe any planning agency, governmental or private, should have the authority to order that private institutions which have served their communities for years should be closed down. We do not believe it is the role of Government in this country to order private institutions not to provide socially beneficial services and to close health care facilities. The proposal actually would represent a taking of private property without compensation, in violation of the Constitution. We oppose it totally.

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(continued) unneeded services and facilities." Similarly, Section 216(d) of the Bill would add a requirement that the HSP include a statement of changes, including reductions, in facilities that the HSA determines are necessary to meet the goals of the HSP. We oppose both these provisions.

The problem posed by Section 219(b) is exacerbated by Section 218(b)(1) of the Bill, which would amend the specification in Section 1523(a)(4)(B) of those health services subject to state certificate of need procedure. The proposed provision would require a certificate of need for the "offering and development within the State of institutional health services...." This language would replace the phrase "new institutional health services proposed to be offered or developed" currently in the Act. It seems, therefore, that the Bill would require the states to subject the offering of all institutional health services, not merely the offering of new ones, to the certificate of need requirement.<sup>\*/</sup> This provision, therefore, could be interpreted as requiring the states to grant a certificate of need for every existing service -- which would only provide additional authority to the planning agencies to terminate any services they determine at any particular time were no longer needed. This provision should be amended to make it clear that the "offering and development" only refers to new services.

The effect of these proposed amendments would be to take effective operating control of hospitals from their own boards, composed of persons concerned with the welfare of their own communities and responsible for the effective and responsive operation of their hospital, and give it to the bureaucrats of State and Federal Government -- persons who would have

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<sup>\*/</sup> The same problem is raised by proposed Section 1527(a), which would be added by Section 218(a).

great power, but little responsibility and accountability for the effects of their actions. This is not planning. This is the Federalization of the health care system.

2. The current provision for appropriateness review should be deleted.

Even now, the Act requires the planning agencies to review the appropriateness of existing health services (Sections 1513(g)(1) and 1523(a)(6)). This provision should be deleted.

At best, it is a meaningless formality, requiring extensive effort by the planning agencies. Since the planning agencies do not have the authority to close facilities or to discontinue services, the appropriateness review is an academic exercise. If the planning agencies need to consider the appropriateness of an existing service in passing on an application, they can do so in that particular case. There is no reason to review the appropriateness of every service.

At worst, however, the appropriateness review can be part of a process by which the planning agencies determine what they consider "appropriate" and then use their authority to approve new services to force the closing of inappropriate ones (a procedure discussed below in Item 6). Since Congress has not authorized planning agencies to close existing facilities, planning agencies should not be able to use their authority to review new facilities to pressure providers into taking actions that the planning agencies are not authorized to require directly.

To the extent the provision for appropriateness review encourages this unauthorized and improper practice, it should be deleted.

3. The planning process should be phased in, starting with the largest and most important expenditures.

As this Committee is well aware, the Planning Act has imposed a huge burden upon the local and state planning agencies, both because of the complexity of the Act's procedural requirements and because of the scope of the health plans required. The planning agencies now are in the throes of developing the health systems plans and the state plans -- a process that has proved more difficult than was originally contemplated. And there are few people qualified to do this job. 'At the same time, the planning agencies are being required to act on applications for approval of new services and purchases of equipment. As a result, the planning agencies are fully occupied just in keeping the paper flowing. They have not had a chance to sort out their priorities, to develop effective administrative procedures, and to make the basic policy judgments which are a necessary precondition of any effective planning. It is, therefore, questionable whether the planning agencies are prepared to implement the Act in its present form in the foreseeable future.

We would propose, therefore, that the Planning Act be limited to expenditures above a specified substantial amount, for instance \$1,500,000, for a transitional period of two years.

4. The certificate of need requirement should apply to all expensive equipment, irrespective of situs or ownership.

As this Committee is well aware, one of the major loopholes and counter-productive features of the existing Act has been the interpretation by HEW that it applies to the purchase of medical equipment only by institutional providers. As a result of this, there has been a proliferation of equipment located outside and independent of hospitals. Because physicians' offices and clinics are considered not to be included within the Act, they have been able to purchase expensive equipment free of review by the planning agencies. As a result, equipment which rightfully should be centralized for the use of the whole community in the hospital is being dispersed in a number of unnecessary and duplicative facilities. The Act should be amended to make it clear that all purchasers of equipment are equally subject to planning review.

We understand Section 218(b) of the Bill to be intended to make that change, and we heartily support that intent. We believe, however, that the provision can be written more clearly.

The proposed amendment to Section 1523(a)(4)(B) refers to the "offering and development within the state of ... major medical equipment." This is not clear; one does not offer major medical equipment (unless he is an equipment manufacturer).



Perhaps the word "use" should be added to make clear the intent as we understand it.<sup>\*/</sup> This is particularly important since the first part of the proposed new definition, referring to "the obligation of capital expenditures," would not cover purchases by physicians of medical equipment; the proposed new Section 1531(6) would limit the definition of "capital expenditure" to expenditures made by a health care facility (an undefined term which HEW currently defines not to include physicians' offices).

5. Used equipment should be exempted from planning review.

We support the concept of proposed new Section 1531(6) which will exempt from the capital expenditures subject to planning review those used to obtain "an existing health care facility the services or bed capacity of which is not changed in being so obtained." We would propose two amendments to strengthen this provision:

(a) It should apply to equipment, as well as to a facility, so as to promote a market in existing equipment, and encourage (and enable) providers with excess or duplicative equipment to sell it.

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<sup>\*/</sup> As discussed above, moreover, the proposed language also should be amended to stipulate that the provision only applies to new equipment and not to equipment currently in use.

(b) The provision should apply if the services or bed capacity of the purchased facility are decreased, as often occurs in mergers, as well as if they remain constant. The word "changed" should be changed to "increased."

6. The ability of planning agencies to take unauthorized actions should be corrected.

We have received numerous reports that planning agencies are using their authority to approve new institutional health services to make other changes in a hospital that they are not authorized to require. This tendency poses a host of problems. For instance, an HSA may refuse to approve the purchase of new X-ray equipment unless a hospital agrees to close its obstetrical service, or an HSA may not approve what it considers to be a new service because the hospital has refused to enter into a merger which the HSA for its own reasons is encouraging.

In effect, one of the major abuses of the Planning Act that is coming to be generally recognized is the fact that the planning agencies have the authority to coerce hospitals into doing things that planning agencies do not have the authority to require directly. If Congress wishes planning agencies to have the authority to close beds and terminate services, it should provide so directly (as H. R. 10460 proposes), and as a necessary corollary of doing so require them to assume operational control and moral and financial responsibility for the facilities. We do not believe Congress wishes the planning agencies to have that authority. If so,

it should make certain that the planning agencies do not arrogate to themselves that authority by their use of what authority they do have. Planning agencies should not be permitted to use their authority as a club to force hospitals into taking actions that they are not authorized to require.

We believe, therefore, that the following language should be added to Sections 1513 and 1523 of the Act:

"The review by an agency or State Agency of any new institutional health service shall be based solely upon the merits of the particular proposal at issue and its effects within the health service area, and shall not include consideration of whether the applicant will take or has taken (or will not take or has not taken) some other action."

7. Local and state planning should be protected from HEW control.

As we understand the intent of this Committee, the Planning Act is designed to provide a system by which planning decisions will be made by local agencies attuned to the needs of the community. In point of fact, however, the local planning agencies have little real power; their authority is only to make recommendations, and the final determination is made by the state agencies. Furthermore, both the local and state agencies are subject to the final authority of HEW -- authority that is vaguely defined and essentially unlimited as a practical matter. We believe that HEW's power over the local and state planning agencies should be lessened and that its authority should be more precisely delineated. This concern is raised by a number of provisions of the Act:

(a) Section 1513(b)(2) of the Act requires that health systems plans be "consistent with" the National Guidelines. This provision, and the enforcement mechanisms available to HEW (discussed below), mean that as a practical matter, the Guidelines are not so much Guidelines as Federally imposed standards. The Guidelines can be used as a vehicle for forcing the introduction into the State and local health plans of practically any concept HEW may at a particular moment find attractive. This was in effect confirmed by Under Secretary Champion, in his testimony before this Committee on January 30, 1978; he asserted that if the Administration's cost containment bill is not enacted, HEW could if it wished insert the revenue limitations of that bill into the Guidelines.

The Act as a practical matter requires state and local planning agencies to adopt the provisions of the Guidelines. HEW has seized upon the language of Section 1513(b)(2) in its recently republished proposed Guidelines and specified that an HSP is consistent with the National Guidelines only if it is at least as stringent as the standards specified in the proposed Guidelines (proposed 42 C.F.R. §121.5). While the proposed Guidelines would give HSA's the authority to deviate from the Guidelines in certain instances, those instances are very narrowly defined ("residents of the health service area not having access to necessary health services") and the proposal would require the HSA to give written detailed justifi-

cation for the adjustment -- a requirement apparently designed to discourage the HSA's from making that adjustment.

Moreover, HSA's will be reluctant to depart from the Guidelines for another reason. If HEW determines that the state and local plans are not consistent with the Guidelines (and, presumably, that an adjustment was not warranted), it can refuse to renew its designation agreements with the HSA and the SHPDA (Sections 1515(c) and 1521(b)). Knowing this, the local and state planning agencies are not likely to deviate from the Guidelines. As a practical matter, therefore, and ultimately as a legal matter, the HSA and the SHPDA represent implementing agencies for the Federal Government.

There is a deceiving facade of local and state planning, but the real power rests, though disguised, with the Federal Government.

To ensure that there will not be Federal control over the planning process, the term "consistent with" should be deleted from Section 1513(b)(2). It is sufficient that the HSA's give serious consideration to the National Guidelines; they should not be required to make their plans consistent with them.

(b) Under Section 1535 HEW is directed and authorized to review and approve or disapprove the budget of HSA's and SHPDA's. No standards are specified for this review. HEW is also authorized to review the performance of each planning agency; in mak-



ing this review, HEW is authorized to consider such vague and all-inclusive factors as the adequacy of the state health plan, the health of the residents, whether the agency has been successful in restraining increases in costs, accessibility and quality of health care, etc. In determining whether to renew the designation agreement with an HSA or a state agency, the Secretary may consider the effects of the review conducted under Section 1535. In effect, therefore, HEW has the authority to impose total discipline over the local and state planning agencies.

To rectify this situation, we believe the entirely vague standards of Section 1535 should be deleted. The HEW review should be limited to determining whether the planning agencies have used Federal money for legitimate planning purposes, without delving into the substantive decisions made by the agencies. At a minimum the Act should be amended to specify that HEW in making these reviews cannot consider the extent to which a state plan or an HSP or AIP is consistent with or deviates from the Guidelines.

(c) Section 1501(b)(1) of the Act currently specifies that the Guidelines shall include "standards." While we understand that to mean that any standards are to be applied as guidelines, i.e., benchmarks and not rigid requirements, the use of that term may be seized upon by HEW as support for requiring adherence by local planning agencies of quantitative specifications contained in the Guidelines. We propose, therefore, that the term "Standards" in Section 1501(b)(1) be

deleted and be replaced by the word "Provisions."

(d) H. R. 10460 would further increase HEW's power over the planning agencies. Section 206 would add a Section 1516(c)(3) which would authorize HEW to override the formula grants provided by the Act whenever it determined that the HSA did not require the amount of money to which it would otherwise be entitled. We strongly oppose that provision. It would give HEW unbridled discretion to set HSA budgets. It represents just one more mechanism with which HEW can control planning.

8. Federal hospitals should be included within the purview of the Planning Act.

In its current form, the Act requires that "new institutional health services" be subject to certificate-of-need legislation. The Act currently defines institutional "health services" (in Section 1531(5)) as health services provided by health care facilities and health maintenance organizations; that definition incorporates regulations promulgated under Section 1122 of the Social Security Act for the definition of health facility. It would seem totally permissible to include within the definition of health care facilities hospitals operated by the Federal Government. HEW, however, has taken the position that the Act does not apply to Federal hospitals. See 42 Fed. Reg. 4007 (January 21, 1977).

We believe that to be fair and effective, the Act must apply equally to all providers, including Federal hospitals.

In many communities health care is provided both by Federal hospitals and by community hospitals. The construction of new Federal hospitals, outside the control of local planning, can decrease community hospitals' occupancy and increase their unit costs. It is obvious that there cannot be effective planning unless all hospitals are included.

In its most recently published proposed Guidelines (January 20, 1978) HEW has aggravated the consequences of not applying the Planning Act to Federal hospitals. In this promulgation, HEW directs the planning agencies in reviewing the needs of community hospitals subject to the Planning Act to consider the Federal hospitals' facilities which are available to residents of the health service area. To include Federal hospitals' capacity in reviewing the need for community hospitals' services but at the same time to permit Federal hospitals to expand regardless of what community hospital facilities are available is totally inequitable, and unwise as a matter of policy.

This arrangement can only tend to increase the Federalization of health care -- contrary to the specific recommendations of the Report of the National Academy of Sciences of June 3, 1977, on Health Care for American Veterans. By this provision, the more the Federal hospitals build, the less will be the role of community hospitals, and since the Federal hospitals can build without planning approval, they will have an unchecked ability to displace community hospitals.

Such a double standard, moreover, represents the ultimate conflict of interest: the Federal Government uses its law-making authority to impose planning restrictions on its competitors, while claiming an exemption for itself.

In our comments on the republished Guidelines, we recommend that at the very least the President should direct by Executive Order that Federal hospitals consent to be subject to the Planning Act. We believe this Committee should propose that the Act be amended so that it specifically includes public hospitals (i.e., hospitals operated by the Federal Government and any other government).

9. The certificate-of-need requirement should be amended to leave room for management discretion.

As mentioned above, we believe that administration of the Act should be phased in by limiting, for a transitional period, certificate-of-need review to the largest and most important expenditures. If such a phased-in limitation is not included, we believe at the very least the definition of the expenditures subject to review should be amended to limit to some extent the planning agencies' intrusion into every minutia of hospital administration.

Providers' management discretion must be preserved and enhanced. Planning agencies and HEW cannot manage the health care delivery system. An effective system requires innovative and energetic managers and trustees. The less is the discretion left to the individual hospital, the less likely

it is that the field will continue to attract such people. Instead, managers and trustees will see their role as winning planning approvals -- their rule will be viewed as political rather than managerial. The Planning Act is itself a significant step down this unwise road. But the Act should at least be limited to certain parameters that leave the individual institution some managerial discretion.

To this end, we believe three limitations should be included in the Act:

(a) The capital expenditures subject to the Act should be limited to those in excess of \$150,000, as would be provided by new Section 1531(b) proposed by H. R. 10460.

H.R. 10460, however, would also go in the opposite direction in one respect. Section 218(b) of H. R. 10460 would add to the definition of a capital expenditure subject to planning review an expenditure, even if less than \$150,000, that "substantially changes the services" of a facility. We see no justification for broadening the coverage of the Act so that it applies to changed, as well as new, services. As a practical matter, this removes all limitations on the applicability of the Act. Planning agencies can and will determine that almost any management innovation is a substantial change in service.



We know of one case, for instance, under Section 1122 (which contains the same substantial change of service definition for expenditures under \$100,000) that demonstrates the extent to which planning agencies will be able to extend their jurisdiction. In that case, a hospital was providing EEG's to patients who drove to the hospital from outlying areas. In order to save those patients time and money, the hospital determined to provide the same services by placing EEG units in several outlying hospitals and connecting those units with the hospital by telephone. In effect, the hospital changed the manner by which it provided EEG's; instead of driving to the hospital to have their EEG's taken, patients had their EEG's delivered by telephone wire. The local planning agencies determined that this was a substantial change in service; the Health Resources Administration of HEW agreed. Only a few thousand dollars were involved.

Extending the planning agencies' jurisdiction to these matters will only squander their resources and prevent them from adequately reviewing the important expenditures. More importantly, it will discourage hospital executives from innovating. They will conclude that an improvement in their services simply is not worth the planning fuss.

(b) With respect to non-capital expenditures, the Act should be amended so that it applies to new institutional health services only if they entail (i) initial expenditures

of \$150,000 or more or (ii) annual expenditures of \$75,000 or more. There is no justification for applying the Act to every new institutional health service regardless of the cost.

(c) Third, we believe the Act should be amended to prevent planning agencies from treating a new way of providing a service as a new service or as a substantial change in service.

For instance, one HSA is asserting that a hospital which has traditionally operated an emergency room with medical staff physicians on call but wishes to hire physicians to provide the same service must obtain planning approval. We believe this is far beyond the intent of Congress. It certainly is unwise. Such an extension of planning review -- with all the delays and contention necessarily involved -- would seriously dampen the innovative spirit of hospital management. We believe that the definition of institutional health services in Section 1531(5) should be amended to provide that: "a new mode or system of providing a health service that was previously provided is not a new institutional health service."

10. The certificate-of-need requirement should not provide special advantages for chain hospitals.

In two instances H. R. 10460, no doubt unwittingly, would provide inequitable advantages to chains of hospitals. As a practical matter, this would benefit proprietary hospitals to the detriment of community, non-profit hospitals.

Section 218(a) of the Bill would add a new Section 1527 (a). This would require that certificate-of-need review be made before the equipment or facilities are acquired and before "substantial expenditures are undertaken in preparation for such offering or development." This can only unfairly advantage the hospital chains. They are able to plan the acquisition of equipment or facilities with the use of in-house personnel and thus avoid any "expenditures." An independent hospital, on the other hand, must hire consultants and other expert persons to assist it in deciding whether or not to purchase equipment, and thus undertake "expenditures."

Similarly, Section 218(b) would add a new Section 1531(6), which would stipulate that in determining whether an expenditure exceeds \$150,000, the "cost" of studies, surveys, etc. be included. This would appear not to take account of the in-house activities hospital chains are able to undertake, but for which community hospitals must contract. Again, this advantages the hospitals that pay dividends from their health-care activities and disadvantages independent community hospitals whose purpose is solely the provision of health care.

We are certain it is not the intent of Congress to promote the expansion and aggrandizement of proprietary hospitals at the expense of community hospitals which have served their communities over the years. We propose, therefore, that the word "expenditures" in proposed Section 1527(a) be changed to

"activities" and that the word "cost" in proposed Section 1531(6) be changed to "value" so that the provisions would apply equally to chain-operated hospitals and independent community hospitals.

11. Cost-saving expenditures should be exempted from the Act.

To encourage hospitals to undertake expenditures which will result in net savings, they should not be required to submit such expenditures to the planning authorities. If an expenditure will save money, there would seem to be no justification for the planning agencies' reviewing it. Accordingly, we propose that a provision be added to Sections 1513 and 1523 providing that an expenditure which will result in a net cost-saving to the hospital or its patients cannot be reviewed by the planning agencies.

In effect, of course, the planning agencies will reserve for themselves the right to determine whether or not an expenditure will save money and thus to determine their jurisdiction over the expenditure period. But this provision would result in the review of such an expenditure being limited solely to its cost-saving potential and thus simplify and, we hope, hasten implementation of the cost-saving measure.

12. The hearing requirements should be amplified and clarified.

We strongly support the provisions of H. R. 10460 that would provide for a hearing on the development of the AIP

(Section 216(e)) and which would provide for a hearing before the SHCC in the development of the State plan (Sections 217 (a) (1) and 217(b) (1)). Hearings are essential to a fair and effective planning process, and this Bill goes far in the direction of curing a weakness in the Act.

We do suggest that the hearing requirements be further strengthened and clarified in six respects:

(a) Section 217(a) (1) is ambiguous in that it refers only to the SHCC's "review functions." The SHCC is required to review and coordinate HSP's and AIP's, Section 1524(c) (1). Similarly, the SHCC is required to "prepare and review and revise" the State health plan, Section 1524(c) (2) (A). Is the proposed amendment intended to apply to only part of the SHCC's activities in these areas? We presume not, since there is no policy reason for limiting the hearing requirement. Accordingly, the word "review" should be deleted from proposed Section 1532(a), as it would be amended by Section 217(a) (1) of the Bill.

(b) The same amendment should be made in Section 1532(a) with respect to the HSA and SHDPA functions. Section 217 (a) (1) of the Bill should provide that the procedures and criteria of Section 1532 apply to the activities of the HSA and SHDPA, like the SHCC, not merely in performing their review functions, but in developing the HSP's, AIP's, and preliminary state plans as well. It is not clear what the term



"review" functions means, but we believe that it should be spelled out in the Act that the planning agencies are required to provide hearings in developing health plans, as well as in considering applications for new institutional health services. The rights of many persons will be affected by the health plans, and those plans should not be developed without a hearing.

(c) The Act should specify the basic requirements for the hearing.

(i) It should make it clear that any person directly affected (a term we propose be more explicitly defined) by a matter be permitted to participate in a hearing. We have heard reports of a hospital that would be affected by a proposal not being able to submit data, but being limited to the role of an observer.

(ii) The Act should specify that hearings conducted by the HSA, State Agency, or SHCC must provide for cross-examination of any evidence submitted to them (but not cross-examination of persons simply stating a position). Cross-examination is critical to test a person's motivations, to probe the validity of data which are provided, and to ensure that the agencies' decisions are based on accurate information. But the Act now contains no recognition of the importance of cross-examination. The Act must be amended to provide cross-examination.

(iii) The planning agencies must be required to keep a transcript of the proceedings.

(iv) With respect to their functions in reviewing new institutional health services, determining the appropriateness of existing facilities, or determining priorities among projects, the planning agencies should be required to base their decision on the information received on the record and not on any extraneous factors.

To make these improvements in the Act, we propose that Section 1532(b) (8) should be amended to read as follows:

"Any person who would be directly affected by any decision or recommendation of the agency or the State Agency may request a public hearing and may participate in such a hearing. Any participant may present evidence and arguments orally and/or by written submission. All evidence received shall be subject to cross-examination, provided that persons merely expressing statements of position shall not be subject to cross-examination. The agency or State Agency shall maintain a record of the hearing, including a reporter's transcript of the proceedings. The decision of the agency or State Agency under Section 1513(f) (g) of (h), or under Section 1523(4), (5), or (6) shall be based solely on the record of the hearing."

(d) A provision should be added to Section 1532(b) to ensure that interested persons receive notice of all applications and actions so that they can participate if they wish. Accordingly we propose that Section 1532(b) (1) be amended so that it reads as follows: "Timely written notification to affected persons of the beginning of a review, and to all persons who have placed their name on a mailing list maintained by the agency, the State Agency, and the Statewide Health Coordinating Council."

(e) The term "person [who would be] directly affected" by agency action is too vague. We believe that at a minimum the following provision should be added to Section 1532:

(A) "Every provider in the health service area is a person who would be directed affected by an agency action; a provider in a different health service area is such a person if the proposal under review could adversely affect the provider."

(B) "Every person who participated in a proceeding before the agency is a person directly affected by a State agency proceeding."

These definitions would ensure that no interested person is barred from participating in the planning agencies' proceedings. They would not unduly broaden them, because a provider would not waste the time and resources to participate unless he was affected by the application.

(f) A provision should be added specifying that each planning body must hold its own hearing; current HEW regulations provide that an HSA hearing satisfies the requirement that the SHPDA hold a hearing, 42 C.F.R. §122.306(a)(7) and §122.407(a)(7). But the issues before the SHPDA will not necessarily be the same as those before the HSA; the HSA's recommendation itself adds a new factor into the planning consideration which must be evaluated by the SHPDA. Interested persons should be able to obtain a hearing on the issues raised by the HSA's recommendation.

13. Judicial review must be provided.

The Planning Act, in its current form, totally fails to provide that persons adversely affected by planning determinations will be able to seek judicial review of the decisions.

Section 218 of H. R. 10460 would add a Section 1527(a)(5) providing "an appeals mechanism" where the State Agency decides not to issue a certificate-of-need upon the request of the applicant. This provision reflects the problem, but does not treat a number of the important problems:

(a) It is unclear whether or not this is a mechanism for judicial review. An "appeals" mechanism could encompass only an administrative review. This would be totally inadequate; a further administrative review of the decision of the state agency is likely to be meaningless since the administrative review agency would be appointed by the same Governor and reflect the same political stance as the state agency. Independent judicial review is critical.

(b) Judicial review should not be limited to situations where the state agency decides not to grant a certificate-of-need. It is equally important that there be judicial review where the State Agency decides to grant a certificate-of-need. For instance, the state might authorize the construction of a new hospital or the purchase of new equipment that violates the state plan; other affected providers should be permitted to obtain judicial review of that decision.

(c) Judicial review should be provided to ensure that state plans are consistent with the Act, that they are formulated in a manner that complies with the law, and that they are not unreasonable. Suppose, for instance, a state plan provided that, to use Washington as an example, all new hospitals in the area were to be constructed west of Rock Creek. The state agency should be required to support such a decision, like any other decision of an administrative agency, as a reasonable conclusion based on the evidence before it and the needs of the community.

Accordingly, to provide judicial review, we suggest the following amendments to the Act:

(i) Add to Section 1522(b):

"(14) meets the procedures and criteria required by Section 1532 and provides that any person who may be adversely affected by a final decision of the State Agency under Section 1523(a)(4),(5), or (6) may, within six months after that decision is entered, obtain judicial review of that decision in an appropriate state court. Upon such judicial review, the decision of the State Agency shall be affirmed if it is supported by substantial evidence upon the record considered as a whole, is not arbitrary or capricious, was made in conformity with the applicable law, and complies with whatever additional criteria the state may establish."

(ii) Add to Section 1524:

"(d) Any person who may be adversely affected by any decision of the SHCC under subsection (c)(2) may, within six months after that decision is entered, obtain judicial review of that decision in an appropriate state court. Upon such judicial review, the decision of the SHCC shall be affirmed if it is not



arbitrary or capricious, was made in conformity with applicable law, and complies with whatever additional criteria the state may establish. At a minimum, every provider within the state shall be considered a person adversely affected by the state plan."

(iii) Change "subsection (c)" at the end of Section 1524(a) to read: "subsections (c) and (d)."

(iv) Section 1522(b)(13) of the Act should be deleted. This provision provides a mechanism for further administrative review where the State Agency does not accept the recommendation of the HSA. This procedure will only delay the process; it is unlikely that further administrative review will change the result since the reviewing agency will be appointed by the same persons who appointed the SHCC and the State Agency. In any event, the provision of the Section 1522(b)(13)(A) that permits only an HSA to trigger the administrative review process should be deleted; there is no reason why an adversely affected provider should not also have that right.

14. The composition of HSA's and SHCC's should be liberalized.

(a) We strongly object to the premise of the Act that membership on the SHA and the SHCC should be parceled out to persons who will represent interest groups. We believe the states should formulate mechanisms so that membership on these bodies is determined on the basis of qualifications such as experience, knowledge, and interest, not on what particular interest group a person happens to represent.

The limitations on provider representation should be eliminated. There is no reason to believe that a planning agency with more providers will be more expansionary than one dominated by consumers. After all, consumers seek additional health care facilities just as much as providers -- indeed perhaps more so than incumbent providers. When a governing body composed of providers acts upon the application of one provider it may adversely affect a number of the providers on the governing body; they may therefore be more likely to vote against a proposal than will a governing body composed of consumers who will benefit from it. If conflict of interest considerations preclude providers from voting in this manner, should not the same considerations also apply to consumers?

If the limitation on provider representation is not deleted, a provision should be added to ensure that hospital administrators, who manage the institutions most directly affected by the planning process, are included on the HSA and SHCC. Specifically, a provision should be added to Section 1512 and Section 1524 requiring that the HSA and SHCC, and each committee, contain representatives of hospital administration in a number at least equal to the direct providers who are not representatives of hospital administration.

(b) A provision should be added that members of the HSA board and of the SHCC will serve limited terms (two years) and that no person may serve more than two successive terms. (Sections 1512(b)(3) and 1524(b)(1))

(c) We support the provisions of Section 209(a)(2) of the Bill, which qualifies for membership providers who work in an HSA but live elsewhere.

(d) The Act currently permits the governing board of an HSA to exceed 30 persons if it has an executive committee (Section 1513(b)(3)). This exception permits the creation of governing bodies that are far too large to take effective action as a body. The exception should be eliminated.

15. No criminal sanctions.

We propose that an amendment be added to the Act specifying that states may not apply criminal sanctions for noncompliance with certificate-of-need legislation. We believe that the sanctions should be directly related to the purpose of the Act; this is fairer and more effective.

16. Non-duplication with Section 1122.

At the present time, an applicant must obtain approval both under Section 1122 of the Social Security Act and under the certificate-of-need legislation. We do not see any benefit in requiring two different approvals and accordingly propose that a provision be added that when HEW enters into a designation agreement with a state agency (Section 1521) that

agreement shall provide that any agreement between the state and HEW under Section 1122 shall be rescinded. Such a provision would not require amendment to the Social Security Act; it would simply be an amendment to the Planning Act requiring HEW to include in one contract a provision rescinding another contract.

17. Uniform accounting and classification of hospitals should be deleted from the Act.

This Committee and Congress have recently considered the appropriateness of uniform accounting requirements in P.L. 95-142. We strongly oppose uniform accounting as an unnecessary, vexatious, expensive requirement that can only be intended to facilitate even greater Federal control over hospitals. Since Congress rejected uniform accounting in P.L. 95-142, we believe it should make its intent even clearer to HEW by deleting the provision from Sections 1502(a) and 1533(d) of the Planning Act.

Further, we oppose the directive in Section 1533(d) for HEW to develop other uniform and classification systems. We do not believe such measures are possible in as diverse a field as the health care delivery system, and the effort can only tend to homogenize and rigidify the field -- a step we decry both insofar as it destroys community hospitals' individual identity and diversity and as it presages even greater Federal control. The bureaucrat requires order and conformity to regulate and control. We believe this Committee should oppose efforts to obtain that control.

18. Other provisions of H. R. 10460(a) Conflicts of Interest (Section 214)

We believe that the proposed section on conflicts of interest is a good approach to the problem. However, we have suggestions for strengthening the provision:

(i) The term "any matter" is far too broad. It would, for instance, seem to apply even to the development of the health systems plan. Since every hospital is likely to be affected by the health systems plan, it might be argued that every hospital employee who is a member of the governing board would be precluded from participating in the development of the plan. Surely, Congress does not wish that result. Perhaps the conflict of interest provision should be made applicable to matters other than the development of the HSP, AIP, and state health plan.

(ii) To the designated relationships, those of "purchaser" and "medical staff" should be added. These relationships are just as likely to create a conflict of interest as are those specified in the proposed amendment.

The medical staff relationship is particularly important. A physician on an HSA board speaks with all of the imputed authority of a physician. He should not be able to speak on whether or not the hospital in which he practices should obtain a particular piece of equipment.

Moreover, it should be made clear that he should not be able to participate in the review of an application of another



hospital. Just as he has an interest in what equipment his hospital obtains, he has an interest in what equipment a hospital at which he does not practice obtains since it affects his practice and his hospital. Perhaps this could best be done, in addition to adding medical staff to the prohibited relationship, by including language in the committee report specifying that anyone on the medical staff of a hospital has a competitive relationship with any other provider if the hospital itself has such a competitive relationship.

(iii) The prohibition should not be limited to voting, but should include any participation.

(iv) The term "substantial," of course, is impossible to define. To avoid litigation after the fact on whether a particular member should have been disqualified as having a substantial relationship of the type delineated, we propose that the Chairman of the HSA be given the authority to determine whether or not a sufficiently substantial relationship exists to warrant disqualification, provided that he makes public disclosure of his determination.

(v) The conflicts provision should apply to the SHCC as well.

(b) Health care insurers should not be afforded special treatment.

Section 208(a) of the Bill would permit health care insurers to give money to HSA's. Health care insurers have their own

motives, which may be advanced or not by HSA's. They should not be in a position to win gratitude from HSA's (as is the necessary result of financial assistance), particularly when numerous other interests affected by the HSA actions are not. There is no justification for sanctioning conflicts of interest to the benefit of one of a number of viewpoints the HSA must consider.

(c) Batching of applications should not delay consideration.

We oppose the provision of Section 218(b)(4) of the Bill, which would amend Section 1532(b)(2) to permit planning agencies to consider applications for one year. That is far too long a period, particularly for the smaller and more routine applications. If the purpose of this provision is to permit batching of applications for review, the following language could be added at the end of existing Section 1532(b)(2):

"provided, however, that any subsequent application for the same or similar service shall be considered with the first one filed, but only if it is filed within 30 days thereafter. Consideration of an application shall not be delayed or deferred on the basis of another application that is or may be filed after such 30-day period."

CONCLUSION

I commend the Committee for delving into the intricacies of the Planning Act in an effort to improve the planning process, and urge the Committee to consider these amendments.



## Statement

of

Ruth E. Kobell  
Legislative Assistant  
National Farmers Union

to

Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
U.S. House of Representatives

February 1, 1978

Chairman Rogers:

I am Ruth E. Kobell, Legislative Assistant for the National Farmers Union, appearing on behalf of our farm family members.

We are pleased to have this opportunity to represent the views of the Farmers Union and we want to express our continued support for the health planning process established through the National Health Planning and Resources Development Act of 1974.

We believe the Act has already shown the importance of comprehensive health planning and we hope that changes made in the law this year will make it an even more effective instrument for providing quality health care service to all citizens at a reasonable cost.

As an organization representing farm people, we are concerned, however, about the imbalance between rural and urban people serving on the boards of Health Systems Agencies, the basic planning unit. Rural and farm people are simply not represented in proportion to their number within the Health Systems Areas. This imbalance cannot help but be reflected in the planning or lack of planning for health care services in rural areas.

All of the same reasons that prevent farm people from participating in other programs and in acquiring other services apply in this instance as well. Farm people are scattered over large distances and their energies and attention are so thinly spread that it is difficult for them to have an impact on something as complicated as areawide health planning. Also, they are almost always outnumbered and often are, as a result, powerless to compete for the attention of health planners, health care providers or government agencies.

The National Farmers Union, therefore, urges that the requirement that members of HSA boards be broadly representative be enlarged to say that HSA boards must include approximately the same proportion of rural people as are in the population in the planning areas. We believe this requirement of rural representation should apply to providers as well as to consumers, as far as possible, because providers in rural areas are often ignored in the same way that rural health consumers are ignored.

We also urge you to accept a change that would provide that consumers only shall vote for consumer members of HSA boards and that providers vote for providers. This change would insure that board members truly represent the views of those they are elected to represent.

The requirement that over half of the members of HSA boards be consumers should be retained and the minimum increased to 60 percent. The proper role for providers is as advisers, but consumers should play the dominant role in deciding what services they want and what they have to pay for those services.

We do not believe that elected officials should be included on HSA boards at the expense of consumers. In many cases, elected officials are also providers. Also, both providers and elected officials are usually located in the urban areas. If the number of consumers is reduced, there will be less possibility for rural people to be represented and heard.

One of the serious problems of planning rural health services is the large geographic areas included in some Health Service Areas and the geographic barriers that isolate many rural areas. Although there may be no need for sub-area planning and sub-area councils in urban or metropolitan areas, it could be an important element in planning for large rural HSAs or in areas of geographic isolation. We believe these sub-area planning units should be encouraged in appropriate HSAs.

We are very pleased that your committee has proposed to provide more funds to HSAs in rural areas by increasing the per capita funding as the population goes down in numbers. We would also encourage you to provide additional funds to HSAs with functioning sub-area units.

An additional 10 cents per capita could be paid to HSAs in rural areas which have functioning sub-area councils with the funds to be used at the discretion of the HSA or under regulations issued by the Secretary of Health, Education and Welfare. Such funds would encourage the creation and use of sub-area units where they are needed and where they can serve an important purpose. Perhaps, it could be limited to medically underserved areas and serve as an incentive for people in those areas to really examine their present services and needs and look for appropriate ways of improving their local situation.

We do not propose to transfer decision-making authority to the sub-area councils, but only to bring local rural people into the planning process.

Rural people were alarmed last year with the National Guidelines for Health Planning issued under the planning act which, if followed across the board could have required many small rural Hospitals to close. Future Guidelines should take into account the different needs of rural areas. There are excess facilities in many areas and it is to be hoped that the planning process will in time give rural people the support they need to determine what facilities they actually need and what services they can rightfully expect. We think the health planning law should direct the Secretary to give rural areas this kind of support and to determine what is appropriate in rural areas.

We also urge that rural interests be represented on the National Council on Health Planning and Development in a formal way. We would like to see rural membership on that council and we suggest that the Assistant Secretary of Agriculture for Rural Development be included as an ex officio member and as an advocate for rural people.



STATEMENT  
OF THE  
NATIONAL RETIRED TEACHERS ASSOCIATION-  
AMERICAN ASSOCIATION OF RETIRED PERSONS  
ON H.R. 10460  
THE HEALTH PLANNING AND RESOURCES  
DEVELOPMENT AMENDMENTS OF 1978  
FOR THE  
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT  
OF THE  
HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE

February 14, 1978

Background:

The National Health Planning and Resources Development Act of 1974, P.L. 93-641, was enacted to augment areawide and State planning for health services, manpower, and facilities. The purposes of this legislation are: to improve the health of residents of health service areas; increase accessibility, acceptability, continuity, and quality of services; restrain increases in cost of providing services; and prevent unnecessary duplication of health resources. The aforementioned considerations are certainly consistent with the steps which must be taken to address the health care needs of our nation's older citizens.

The aged are highly visible users of a wide spectrum of health services. Of the more than 23 million older persons who were enrolled in the Medicare program in 1977, approximately one in five used inpatient hospital benefits. Indeed, the federal government is beginning to stagger under the weight of the costs of the Medicare and Medicaid programs which are estimated to reach \$37 billion in 1978.

Although the aged constitute less than 11 percent of the population, they account for 29 percent of personal health

care expenses. Since Medicare legislation was enacted on their behalf, it should come as no surprise that they represent the bulk of the expenditures for this program. Many are surprised, however, to learn that Medicaid, which is usually perceived as a program for welfare mothers and their children, devotes 38 percent of its expenditures to older persons. Despite these high contributions by the government to offset the costs of health care, the aged are still left with a substantial portion of the health care bill to pay out-of-pocket. The average health bill for an older person in Fiscal Year 1976 was \$1,521. Of this amount, 26 percent was paid directly by individuals. These high costs place many older persons at a severe disadvantage. The expenses associated with long-term care in an institution are even more ruinous and often lead to total destitution. A reflection of this is the fact that 47.5 percent of nursing home patients whose costs were paid by Medicaid in 1974 were not initially poor, but depleted their resources and qualified as medically needy.

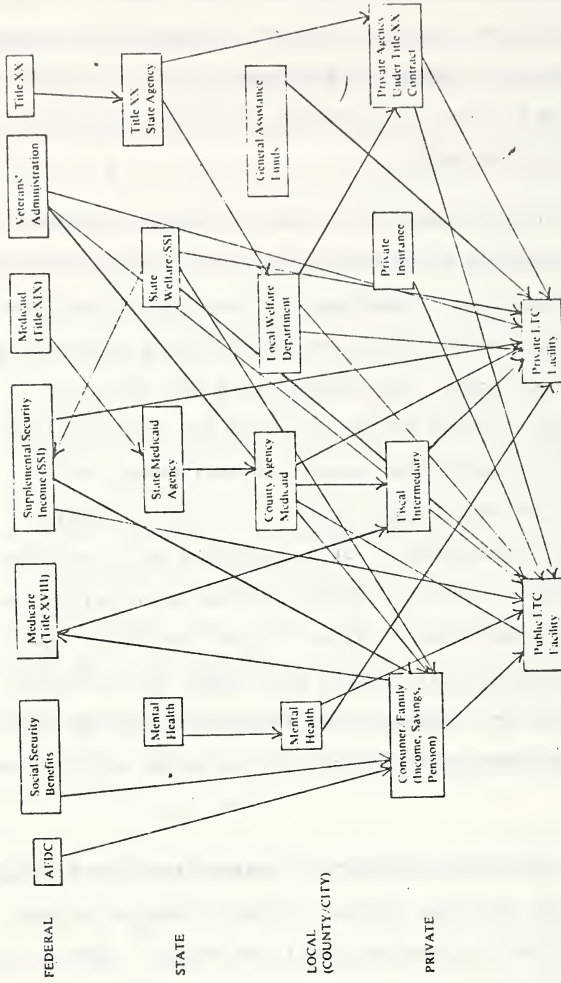
Because of the high costs of health care, the aged members of our society welcome efforts to control the rate of increase in these costs. Cost control alone is not a sufficient answer by itself, however, because not all services

which older persons need are currently available. One of the great challenges facing those who implement the National Health Planning and Resources Development Act is to help bridge the gap between the services that are needed and those which are available.

The area of long-term care offers a suitable example of what is presently wrong with the current system of meeting the needs of the aged. Many who need services do not obtain them either because services are not available or no means exist to pay for them. Our country does not have an adequate supply of home health agencies and day hospitals nor do we have a sufficient amount of sheltered housing facilities. The health care needs of the aged usually bear a close relationship to other services which are more social-oriented in nature. While such tasks as helping an older person to eat, bathe, dress, clean the house, and run errands do not traditionally fall under the category of health, they are indispensable elements which may mean the difference between living at home or being institutionalized.

Although various governmental programs have been designed to address some of these needs, no single program is comprehensive enough to provide what is necessary. The accompanying diagram gives some indication of the complexity of

Table V  
LONG-TERM CARE FINANCING — FLOW OF FUNDS



Source: Joe, T. and Meltzer, J. Policies and Strategies for Long-Term Care, Long Term Care and Health Services Administration Quarterly, Vol. 1, No. 3, Fall 1977.



existing programs in terms of the funding mechanisms and layers of government involved. While it is true that there are many programs, they do not interdigitate with one another in any meaningful way. Each is characterized by different eligibility criteria; types and duration of services; and levels of reimbursement.

The problem is compounded by unclear definitions and terminology. A home health aide in one program may be defined as a homemaker in another program. The wide variety of terms used in the long-term care area are confusing to both health professional and client alike. Some of the more commonly used terms are: skilled nursing facility, intermediate care facility, nursing home, boarding care home, homemaker-home health care, custodial care, sheltered housing, congregate housing, domiciliary care, and personal care.

Health systems agencies and state health planning and development agencies which attempt to unravel this confusion are confronted with a lack of data regarding both the providers of these services and the individuals who need them. Little information is known about those who currently receive services. Even less is known about the home-bound who may need them, but do not receive them.

Immediate attention must be given to this situation. The problem is not a static one because unless remedial steps are soon taken, existing deficiencies will be exacerbated by a noticeable increase in the segment of the population that will require long-term care services.

The Congressional Budget Office estimates that the potential demand for long-term care services will increase from 5.5 - 9.9 million persons in 1975 to 6.3 - 11.1 million in 1980 and to 7.4 - 12.5 million in 1985. This is primarily due to the fact that the 75-and-over age group is the fastest growing segment of the U.S. population.

Since 1900, the proportion of persons 75-and-over, among all those 65-and-over, has increased from 29 percent to 38 percent and is expected to reach 45 percent of the aged population by the year 2000. It is projected that those in the 85-and-over age bracket will constitute 11 percent of those 65-and-over in the year 2000.

Age is closely related to ability to carry out independently the customary activities of daily life. A study of physical performance showed that 19.8 percent of those 65-74 years of age had substantial limitations in such activities as walking, climbing, and bending. This compares

with 42.4 percent of those 75-and-over who had such limitations.<sup>1/</sup>

Meanwhile, the overall number of persons 65 years of age and older will continue to grow sharply. Shortly after the turn of the next century, there will be 30 million members of this age group. By the year 2020, there will be 40 million.

This lengthy narrative has been presented to highlight the importance of older persons in any discussion of health care. Our nation has more nursing home beds than it has acute-care hospital beds. Almost all of the nursing home beds are occupied by older persons. Furthermore, at any one time about 40 percent of the hospital beds are also filled with older persons.

Our society is rapidly growing older. The population will increasingly consist of high proportions of those in the older age brackets. Unless some rationality is introduced into the present system of providing health care services, that system may eventually be overwhelmed by the increased demands made upon it by older persons.

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<sup>1/</sup> Ball, R. M., United States Policy toward the Elderly, in Care of the Elderly, edited by Exton-Smith, A.N. and Evans, J. G., London: 1977, pp.20-32.

From the perspective of NRTA-AARP, this is the major challenge facing health planners. It is within this context that we make the following remarks concerning H.R. 10460.

Our Associations approve of amending Section 1502 by adding two new national health priorities which reflect the need to discontinue unneeded services and adopt policies to contain health care costs. The consequences of perpetuating the status quo threaten the ability of the federal government to maintain existing programs such as Medicare and prevent the expansion of existing benefits.

It is our belief that HSA staff should include individuals with knowledge of and skills in community organization; educational development; public health; and prevention activities. While still recognizing the importance of employing individuals with: administrative skills; abilities to gather and analyze data; and expertise in planning, it is also vital to have staff members who can work with the necessary elements in the community to foster acceptance of the Health Systems Plans and the Annual Implementation Plans.

One cannot help but feel that the recent Congressional outburst manifested by the passage of House Continuing Resolution No. 432 by a 357 - 0 count might have been avoided if HSAs had initially done their work properly. The current

activities of HSAs are virtually invisible and will continue to be until at some future time important segments of the community find out that certain health services will be curtailed in the names of economy and efficiency. When that occurs, the results will be as predictable as the reaction of the members of Congress to the planning guidelines.

We urge that H.R. 10460 take these factors into account when renewing P.L. 93-641. Section 1512(b)(2)(A) of this Act should be amended so that specific mention is made of community organization and educational development as being requisite skills of HSA staff. It is encouraging to see that H.R. 10460 recognizes the need to hire individuals who have some training in public health and prevention activities since the present tendency is too medical care-oriented.

Related to the need for gaining public acceptance is the composition of governing boards. It is unlikely that any formula will satisfy the demands of the various interest groups that would like their respective voices heard in the planning process. Selection of governing board members on the basis of such factors as ethnicity, gender, age, and geography does not inherently guarantee that those chosen will represent any views broader than their own. Unless a particular board member is the delegate of an identifiable constituency



which represents the interests of a broad societal grouping, there is no guarantee of accountability. While our Associations would like to have older persons on all governing boards for reasons described in the introductory narrative, we are cognizant of the difficulty in selecting representatives who can speak for the diverse interests of all older persons in the community.

As matters now stand, the only governing board members who are directly accountable are those who have been elected to public office. Having the support of elected officials is a necessary ingredient to successful planning. It is for this reason that we support the inclusion of public officials on governing boards on some quota basis. While unsure of the exact degree of representation that needs to be expressed in percentage terms, we feel that a figure should be chosen which guarantees this type of accountability. We recommend that Section 1512(b) (3) (C) (iii) of the Health Planning Act be amended to reflect this change.

We are pleased to see that H.R. 10460 recognizes the need to allow authorized grants to be extended from one grant or contract period to another without being deducted from the amount of the subsequent grant or contract. Amending Sections 1513(C) (3), 1516(a), and 1526(C) (1) should take care of this matter. It is important that this change be made to prevent

agencies from spending money for the sake of spending it merely to insure that subsequent grants will not be reduced because of a failure to spend previous awards.

Related to an earlier suggested amendment regarding HSA staff, our Associations are in favor of designating specific funding for the education of the general public along with groups such as elected officials about the goals and purposes of health planning. Section 1516(a) should have exact language specifying the allocation of funds for such purposes. It is particularly important that members of State legislatures be included in this educational process to offset the possibility of having certificate of need rulings circumvented by the passage of State laws which exempt certain institutions from conforming with adverse rulings.

We are also pleased to see that H.R. 10460 recognizes the need for adequate funding to carry out the purposes of the Act. Lack of funds may be a special problem for HSAs covering wide geographical rural areas since most of the budget can be consumed by expenses associated with travel. Close attention should be paid to such agencies to insure that they have ample funds to achieve the purposes envisioned by the passage of planning legislation.

Section 1523(a)(4) of P.L. 93-641 also needs to be amended in other fundamental ways if certificate of need is to be an effective tool in controlling health costs. We approve of the provision in H.R. 10460 which will require the maximum amount of capital expenditures, if any, that may be made in connection with services to be specified.

Existing institutional health services should be granted CONs for specific time periods and CON programs should be given authority to discontinue existing services. The proposed amendment to Section 1523(a) should be instrumental in achieving this end. Appropriate enforcement mechanisms should also be developed to bring institutions, found to have unneeded services, into compliance.

In line with this, we recognize the need to provide payments to institutions to offset any outstanding debts which result from either closure or conversion of under-utilized or unneeded health care facilities or services. We also note the necessity of amending Section 1531(5) so that CON requirements are expanded to include services and equipment valued at more than \$150,000 regardless of location. The recent proliferation of CAT scanners in the absence of cost-benefit analyses testifies to the need to control burgeoning expenditures through such means.

In summary, NRTA-AARP support the major provisions of H.R. 10460 since the National Health Planning and Resources Development legislation is an integral component of the action that must be taken to provide health care on an equitable basis at affordable costs. Strengthening P.L. 93-641 is also important within the framework of proposed legislation to control health care costs.

While health planning offers one means of controlling costs on a long-term basis, there is an immediate need to curtail health spending in some interim fashion. This need was recognized by the prompt action taken by the Senate Human Resources Health Subcommittee and the House Interstate and Foreign Commerce Health Committee on the Administration's hospital cost containment proposal, H.R. 6575.

Both of these subcommittees recognized the necessity of imposing either a moratorium or a ceiling on capital expenditures. Passage of hospital cost containment legislation was recently placed in jeopardy by the decision of the Ways and Means Health Subcommittee Chairman to grant hospitals the opportunity of restraining their rates of increase on a voluntary basis. This in effect puts an end to any effort to control capital expenditures. In light of these developments, we urge that P.L. 93-641 be amended in a way that takes into account the necessity of controlling capital expenditures on a national basis by imposing either a moratorium or a ceiling similar to that proposed in H.R. 6575.

STATEMENT  
LOUIS C. MURRAY, M.D.  
PRESIDENT, FLORIDA MEDICAL ASSOCIATION  
ON H.R. 10460, THE HEALTH  
PLANNING AND RESOURCE DEVELOPMENT  
AMENDMENTS OF 1978 TO  
INTERSTATE AND FOREIGN COMMERCE  
SUBCOMMITTEE ON HEALTH

As President of the Florida Medical Association, I would like to complement the Interstate and Foreign Commerce Subcommittee on Health for addressing the need to revise PL 93-641, Health Planning and Resource Development Act. The task is critical if you are to insure that local responsibility and initiatives are to be the basic foundation of this country's health planning efforts. We appreciate this chance to present our views on some of the changes needed.

The current law does not give sufficient flexibility to local areas to deviate from national guidelines. It is certainly appropriate, and cost efficient, that guidelines and recommended standards be developed at the national level. These should be considered only as guidelines, not mandates to be followed by HSAs. Wide latitude must be given to HSAs to adopt plans to meet local or regional situations, and the burden of proof to demonstrate them inappropriate must rest with HEW, not the HSA. We urge you to adopt amendments to insure this.

The Subcommittee has under consideration an amendment to require a certificate of need for purchase of physicians' office equipment in excess of \$150,000. Numerous studies have been done showing that CON has had little or no effect on cost containment and, in fact, may lead to an increase



in costs. Requiring a physician to obtain a CON for purchase of equipment for his office will create an inequitable situation for non-institutional providers who wish to offer services at a lower cost on an ambulatory basis since CON has given institutions a franchise on certain equipment, creating a costly non-competitive situation. For example, only 12% of CAT scanners are located in a non-institutional setting, and this trend is continuing to hold true for new purchases.

Also, we strongly urge you to reject the concept of CON for physicians' office equipment. To accept it, means a commitment toward ever-increasing regulation of a physician's office practice in terms of expansion of personnel and office facilities. I hope that none of us consider this as a desirable objective.

Under the original comprehensive health planning concept, it was envisioned that the health planning process should be governed by boards composed of a majority of consumers. Recognition was given to strong provider representation, but mandated to be less than 50% of the total board membership. PL 93-641 reaffirmed the consumer majority requirement, and most important, also recognized the necessity for providers to play an active role. The "Findings and Purpose" section of the Statute states:

"Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns

of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels."

We commend this mandate for an active role by providers, and hope it will continue to be recognized as essential to an effective health planning effort. Unfortunately, provisions in the current law and implementing rules and regulations have tended to discourage an active role by providers. We suggest that amendments are necessary to carry out this original intent of PL 93-641. To accomplish this, we suggest adoption of an amendment to eliminate the "indirect provider" classification from the law. This would then guarantee that the minimum provider requirement for membership on HSAs and the SHCC are true providers of medical care with the expertise necessary to play a meaningful role in the decision-making process.

Some have indicated to the committee that providers dominate the health planning process. Nothing could be further from the realities of actual operation of HSAs and the SHCC in Florida. Not only do providers not "dominate" the process in Florida, but we are seeing the development of a distinct "anti-provider" philosophy that in some instances results in boards making decisions on the basis of "consumer" versus "provider" rather than the needs of the community. Many who promote the fallacy of provider "domination" are the very ones who, in fact, would prefer no provider role at all. This, in our opinion, would be a disastrous step to the entire process.

The committee has under consideration an amendment to require the Governor and/or Legislature to "sign off" on the state health plan. This can be a valuable mechanism in checking any imbalance of provider or consumer input at the HSA or SHCC level, as well as involving the executive and legislative branches of state government in the health planning effort.

The Florida Medical Association has established a special Committee on HSAs to encourage the physicians of Florida to become more involved in the health planning process. This represents a commitment on our part to play an active and constructive role. We need your help in making the law more responsive to input, particularly at the HSA level.

Thank you for your consideration of these comments. The FMA Committee on HSAs is developing additional recommendations which will be forwarded to your distinguished chairman. Please let me know of any additional information that can be provided.

STATEMENT OF THE HEALTH POLICY PROGRAM  
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

SUBMITTED FOR THE RECORD  
OF THE  
HEARINGS ON H.R. 10460, THE "HEALTH PLANNING AND RESOURCES  
DEVELOPMENT AMENDMENTS OF 1978"

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
HOUSE OF REPRESENTATIVES  
FEBRUARY 1, 1978

Background

At the request of the Subcommittee we are submitting the following statement of our views on Public Law 93-641. Before making our comments, however, we thought it would be helpful to explain the involvement of the Health Policy Program with that law so that our views can be understood in that perspective.

From 1975 to 1977 we studied for HEW the possibilities for cooperation between Health Systems Agencies (HSAs) and Professional Standards Review Organizations (PSROs). In the course of that study, we visited developing HSAs and PSROs around the country, interviewed a number of officials in state and regional offices, and had extensive working contacts with the Bureau of Health Planning and Resources Development (BHPRD). Since that time we have been engaged in a study of economic regulation in the health field and the need for coordinating HSA activities, not only with PSROs but also with rate setting programs, insurance regulation, and facilities and personnel licensing.

We have also spent considerable time working with state governments, particularly California, examining the state role generally in the health field. Recently the California State Legislature asked us for assistance in understanding the options available to the state under PL 93-641 for both health planning and certificate-of-need.

Finally, a number of members of the Health Policy Program had experience during the period from 1965 through 1971, as officials of DHEW, in funding, implementing, and evaluating comprehensive health planning agencies under the predecessor law to PL 93-641.

The work on this paper was made possible by a recent grant to us from the National Center for Health Services Research. The purpose of the grant was to support creation of a National Center for Health Services Policy Analysis to provide assistance and analysis to federal officials and others on policy questions.

We have grouped our comments and recommendations into the following sections:

1. A general discussion of whether certificate-of-need is effective, in particular, what can and cannot be expected of the agencies set up under the 1974 Act
2. The role of state government
3. HSA and PSRO coordination
4. Current problems and limitations of certificate-of-need controls
5. Decertifying existing facilities and services.



# 1. Is certificate-of-need regulation effective?

Recent evidence indicates that certificate-of-need review has not been as effective as had been hoped in limiting capital expenditures. These apparent failures have been blamed on many factors, including loopholes in coverage of certificate-of-need laws, and inadequate incentives to control expenditures at the local level. All of these explanations point out the enormous gap between certificate-of-need in theory and in practice. As a device for limiting capital expenditures, this regulatory strategy has been given little more than half a chance to be tested. Agencies have been faced with mixed mandates, complex structures, and half-hearted sanctions, and have had to operate under severe political constraints. Although it is too early to dismiss certificate-of-need and health planning on the grounds that they can never be effectively implemented, documented successes are still few and far between.

Even if it were fully successful in limiting capital expenditures, however, certificate-of-need cannot be expected to control total health care costs. This is because certificate-of-need laws provide no direct control over non-capital costs, or the number of units or services provided, or the price charged for each unit. All of these factors can inflate total health care costs even if capital expenditures are controlled.

If the expectation was that the Act would be a major force in slowing down the rise in medical care costs, our answer is that it will not be effective for that purpose. The regulatory structure is unable to respond to the strong and complex economic and political structures to which it is exposed. The major economic forces are not under the control of the agencies. They do not determine the flow of dollars from public and private insurance that is feeding the current cost inflation. They do not have the power to change the cost reimbursement and fee-for-service payment system that is absorbing those dollars.

On the political side, we found in surveying HSAs that their attempts to control costs are generally confined to trying to prevent creation of additional facilities and services that are clearly unnecessary. Any further cost control measures expose them to the charge that they are reducing the quality of care or access to care. Organized community and professional groups fight against such claimed reductions and there is no constituency on the other side. In this setting, it is easier for the HSA to approve most requests than to devote its limited resources to differentiating between legitimate claims and those that arise from provider or community self-interest.

In short, cost control is a national priority but not an individual or local priority, since rising costs have little impact on out-of-pocket payments by local consumers of medical care. More generally, the most that can be accomplished by the program, even if it were maximally effective, would be to slow the growth of certain types of capital expenditures. Since this can be offset by increased utilization or investment in equipment and services not requiring review by the HSA, total hospital costs can still continue to rise.

The structure and authority in the Act, and the regulatory approach, are more appropriate and potentially more effective for improving access than for cost containment. Whether, in fact, access will be improved depends on several factors, including the motivation and composition of the staff and board and the degree to which HSA plans are supported by state policy and actions. In their review and approval of new facilities, HSAs can set conditions that help to improve access, such as requiring a hospital undergoing reconstruction to relocate in an underserved area or to reach out in various ways to serve such areas. The HSA power to veto federal grants that do not serve such areas can also be used. HSA powers can be used to promote the development of health maintenance organizations and other organized medical care systems and their location in and outreach to such areas. While the fact that the composition of the HSA Board is prescribed does not assure an emphasis on improved access, it may make it more likely than before that consumers representing underserved areas will be on the board or able to influence it. If that happens, and the HSA takes an aggressive approach to access issues, the local agencies should be able to make some inroads on service availability.

However, major changes in access will probably not be achieved until the insurance programs expand to include groups now left out or other changes are made in payment systems to encourage physicians and other providers to search out underserved populations.

The agencies created by the Act have no direct responsibility for technical medical quality; however, they are actively concerned with quality as perceived by consumers. Thus, they are quite conscious of factors such as waiting time for services, the character of outpatient facilities, and the ease of access to primary care. But to deal with technical aspects of quality, the agencies need to rely on the professional opinions of the direct providers on the board, or to consult outside professional groups. All these groups, such as subspecialty societies, represent a particular point-of-view and will reflect that bias. Of all the organized professional groups, Professional Standards Review Organizations (PSROs) should be the least self-interested since they must accommodate the diversity of medical opinion. PSROs could provide HSAs an indication of whether an institution is providing generally adequate care and of how HSAs' actions will affect medical quality, and HSAs can then accommodate these opinions to their own notions of quality medicine.

In summary, it appears that the Act can only make some limited contributions to cost control by correcting gross abuses or excesses in the medical care system. It may promote improved access to some groups now clearly underserved, and it may prevent serious abuses of quality where there is no professional dispute about the standards required.

Although the Act can produce some gains in these three areas, it should be cautioned that the same mechanisms available to the

HSA for contributing to a more rational allocation of resources can also lead to perverse results. The regulatory powers can be used to protect existing hospitals and physicians from the competition of more efficient providers. They can stifle innovations such as health maintenance organizations (HMOs) and ambulatory surgical facilities.

The proposed amendments would take one step toward preventing such perverse results by not subjecting HMOs to greater regulation than other providers. However, in areas where there is a bed surplus and no new certificates-of-need are being issued, HMOs would have to buy existing facilities in order to expand. The owners of those facilities in such a situation will be able to demand inflated prices because it will be a seller's market, and this has already occurred in some places. We recommend that the committee exempt HMOs from certificate-of-need controls, or at least specify that determinations of need for HMOs be based on the population to be served by the HMO and not the presently used general ratio of facilities to people in the area.

We also suggest that the Committee explore various devices for exempting from cost control regulation those HSA areas, or parts of HSA areas, where aggregate cost increases are within some specified limit deemed to be acceptable.

Finally, there are some serious conflicts among the goals set forth in the Act, in particular, conflict between cost control and improving access and quality. As a first step, the amendments should set realistic national priorities for emphasis in HSA activities so that the program will have identifiable goals by which its success or failure can be evaluated. Following that, it would be appropriate for the Congress to plan to conduct a definitive review of the effectiveness of the Act within three to five years.

## 2. The role of state government

The current state role. Although the federal planning law called for a series of interrelated local, state, and federal agencies, the relationships formed among these bodies and the way they actually share responsibilities vary widely from state to state. State and local factors which determine the end result include the power base of the Health Systems Agencies (HSAs), the degree of interest which the legislative and executive branches have in health planning and regulation, the substance and procedure of the state certificate-of-need law, and the character of the State Health Planning and Development Agency (SHPDA) and the Statewide Health Coordinating Council (SHCC). New federal legislation or amendments, which the present review might produce, could change all of this, particularly if a lid is put on capital spending. Until then, the key factor influencing agency relationships will be the extent to which the federal government requires compliance with national standards and methodologies and makes the continued funding of the state and local agencies depend on such compliance.

Some state officials in California complain that the structure allows HSAs to dominate the planning and certificate-of-need process. They point out that plans originate at the HSA level, and HSA representatives will form a majority of the membership of the SHCC, which produces the final local and statewide plans. Since certificate-of-need decisions are to be based, in part, on those plans, these officials believe that the HSAs are the dominant entity.

Our studies of other states, however, convince us that the allocation of authority under the Act is so ambiguous that there is room for states to play a somewhat stronger role. They might be able to control the SHCC through the governors' authority to select the HSA representatives and to designate the balance of the appointees. Moreover, the SHCC will depend on the State Health Planning and Development Agency for staff. Where these powers are utilized and SHCC vigorously asserts its right to modify local plans, HSA planning power can be tightly controlled by the executive branch. Where this is not the case, HSAs will do their planning largely on their own.

The state legislature can play a strong or weak role, since it ultimately possesses the licensing and certificate-of-need authority. If legislators set up the certificate-of-need process so that the state agency rarely disagrees with HSA reviews, HSAs will be quite independent. But if certificate-of-need laws establish clear-cut priorities or specific criteria, or call for independent reviews by SHPDA, the state will dominate HSA decision-making.

Similarly, local government can play a limited or extensive role. In most areas, this role will consist of trying to influence the HSA as a member and an interested provider. The few local governmental bodies which are HSAs, such as some California counties, will obviously be in a different position.

Finally, it is not clear how the HSA and SHPDA will answer to DHEW. If DHEW funding for those agencies is conditioned only on their meeting certain operating standards, such as board composition and staff competence, then the HSAs will have substantial autonomy. Also, the federal regulations promulgated to date concerning state certificate-of-need criteria are only minimal requirements, leaving substantial leeway at the state level. On the other hand, if federal standards, such as the proposed National Health Planning Guidelines are promulgated and enforced and funding is conditional on compliance with them, HEW will play a dominant role.

Are these relationships appropriate? Based on our experience, it appears that certificate-of-need functions are appropriately assigned under the present law. The HSAs must do a review because local conditions and values vary greatly, and the impact of such decisions on the availability of services will be felt on a local level. On the other hand, the final certificate-of-need and appropriateness decisions must be made by a statewide agency if there is any chance to make rational allocations of resources. The present structure allows the SHPDA or any other state agency under the governor's direction to make these decisions. A number of groups contend that there would be less political influence if the SHCC or another independent commission had this power.



We believe that keeping this power within the state executive branch makes it more likely that certificate-of-need decisions will be coordinated with other regulatory responsibilities, such as licensing and rate review. It also places certificate-of-need in the general political framework of state government and not in the special and often more hidden politics of independent commissions.

More serious issues are present with regard to the planning structure and authority. First, the long-range plans move "up" from the HSA to the statewide level, rather than vice-versa. Without very specific state or federal priorities, formats, and methodologies, HSAs will develop local priorities which are likely to differ widely from one another, and from statewide and national ones. The task of incorporating the local plans into ones that make sense for larger and even interstate regions may be nearly impossible.

Second, the plans are supposed to be coordinated and revised by the SHCC. This new body is a governmental appendage out of the traditional lines of authority. The present law intentionally gives the state little control over the SHCC. Yet the state is to rely on the SHCC to produce a plan for the entire health care system in the state, a plan that the state government is supposed to implement. Plans produced by such agencies may well be regarded as foreign to state government. The SHCC will have no power to coordinate its plans with other state activities. And the state may make its certificate-of-need decisions without giving much or any thought to the SHCC plans.

**Recommendations.** The present review of the 1974 Act should seriously re-examine the role assigned to the state government. The complex structure diffuses responsibility among a series of governmental and quasi-governmental bodies, in large part bypassing traditional state and local government agencies. In trying to assure local participation and ultimate federal control, the planning law has resulted in confusion of authority and a lack of direction. Instead of utilizing state and county health agencies to their full advantage, the Act turns these bodies, in part, into adversaries. In particular, the SHCC seems an unnecessary entity.

A number of changes should be considered that would increase the role of state government. The annual implementation plans should be tied to federal and state priorities and subject to revision at the statewide level. HSAs should not be left to determine annual priorities on their own, although they should play a major role in identifying specific local needs. States should at least be able to designate health service areas within federal guidelines. Similarly, state government should also provide for formal approval and adoption of statewide plans by an agency of state government and should require local and statewide certificate-of-need criteria to be consistent with statewide needs. Finally, if state government is as important in this process, as we have indicated, the SHCC should be eliminated.



The significance of the HSA having near-total control over the "Area Health Services Development Fund" cannot be determined until it is clear how much will be appropriated for what. If the funding is substantial, it will be important that state and national priorities -- not just local preferences -- be reflected in projects. Therefore, both federal and state government should have a major role in funding decisions.

Another change in the present structure that should be considered is to require states to coordinate certificate-of-need and health planning with other cost-containment programs, particularly rate-setting, where such programs are in place. The consensus of researchers and the available evidence strongly support the notion that these should be closely linked. Similar arguments exist for bringing in utilization controls and insurance regulation as well. What is not clear, however, is how best to do this. While the programs should be functionally related, there is no agreement, for example, about whether they should be in the same agency. Accordingly, it seems appropriate to stimulate or require states to work out arrangements for bringing these programs together, but not to mandate a single structure at the present time.

On the other hand, the HSA program should be fully integrated into any new federal cost-control programs. In particular, a limit on total capital expenditures would drastically change the situation facing HSAs. Either the state or federal government would have to allocate capital expenditures to HSA areas. Leaving an HSA to set its own limits could result in the total expenditure exceeding the desired target.

### 3. HSA and PSRO coordination

Summary and recommendations of the HPP study. In late 1974, just before passage of the planning legislation, the Health Policy Program began a two-year field study of what relationship should exist between Health Systems Agencies and Professional Standards Review Organizations. The final report, "Cooperation Between Health Systems Agencies and Professional Standards Review Organizations," was completed in January 1977. Our study led to the conclusion that there are two areas in which it may be impossible for either program to do its work properly without help from the other. HSAs cannot do health planning without the kind of data that can only be generated by the PSRO network. In turn, it may be hopeless for PSROs to try to change utilization practices unless HSAs can hold down the supply of beds and services. In spite of their interdependence, cooperation to date between HSAs and PSROs has been limited by their different membership, by restrictions on release of PSRO data, and by ineffectual HSA tools to control supply.

Based on our study, we made a series of recommendations, which are reprinted with a few modifications below. These primarily call for action by local HSAs, state agencies, and DHEW to overcome the barriers to HSA-PSRO cooperation. We feel that there is no need for further legislation at this time, particularly since the recent PSRO

amendments and regulations should pave the way for sharing of data and information. While we feel that there are definite benefits to be gained from a degree of HSA-PSRO interaction, we must caution that the programs should remain separate for two reasons: to avoid physician domination of consumers, and to continue to motivate physicians to cooperate with PSROs. Nevertheless, there has been too much delay already in making progress toward a cooperative relationship. Accordingly, we recommend that Congress make clear to DHEW that it expects an effective and consistent program for HSA-PSRO cooperation to be in operation as soon as possible. To emphasize its commitment to improving the mutual effectiveness of these programs, the Congress should also monitor progress toward HSA-PSRO cooperation.

**Recommendations.** The recent PSRO amendments and regulations could represent a major step toward lowering the barriers to HSA-PSRO cooperation and are entirely consistent with the recommendations of our January 1977 report. The fundamental problem remains one of balance and proportion -- to get enough cooperation on specific issues but not too much on broad goals. What is needed is a relationship that preserves some tension between the agencies and independence on either side. Neither should be bound closely to the other and specifically the HSA should not slip into depending solely on the PSRO for judgments on quality.

(1) HSAs should request, and PSROs should provide, aggregate data describing medical services and how they are used, both in the community as a whole and in individual hospitals and other institutions. HSAs should develop the capability to use such data effectively.

(2) PSROs should also provide to HSAs on request copies of the norms, standards, and criteria by which the PSROs review the quality and appropriateness of medical care.

(3) HSAs should not request from PSROs, and PSROs should not be required to release, data from which individual patients can be identified or findings of reviews of the quality of care provided by individual physicians or within specific institutions. But PSROs should be allowed to release information on the quality of care in individual institutions where they judge that it is necessary to do so for their purposes.

*(HSAs were required by regulations to secure data from PSROs. However, the regulations required under the PSRO law to authorize sharing of data were not published until early 1978, and only after the Congress had acted to modify the PSRO law in PL 95-142. PSROs are now required to release data to HSAs and the SHPDAs. Delays are still possible, however, because the new law precludes identifying "any individual" and the recently published regulations prohibit identifying practitioners as well as patients, either directly or indirectly. Since this is likely to be narrowly interpreted by PSROs unwilling to release hospital*

*utilization data, further amendments to the law or regulations may be required to settle this issue. In that case, it could still be some time before HSAs ever receive PSRO data.)*

(4) HSAs should seek PSRO opinion on the potential impact of HSA decisions and actions on the quality of care but should not be bound by that opinion.

(5) HSAs and PSROs should be required to meet periodically to discuss joint action to make each more effective. HEW should evaluate such joint actions to determine the impact on the cost of services, as well as on quality and access.

(6) Where agencies are already functioning, no federal action should be taken to compel realignment of different HSA and PSRO geographical boundaries to make them the same, but federal assistance should be given to the agencies to help them minimize technical problems that result from such incongruities.

(7) The respective federal bureaus responsible for funding PSROs and HSAs (the Health Standards and Quality Bureau and the Bureau of Health Planning and Resources Development) should promote projects to test methods for HSA-PSRO cooperation in selected fields.

(8) The steps required to implement the foregoing recommendations can be accomplished through some new regulations and modification of existing regulations without further amendments to the law.

#### 4. Current problems and limitations of certificate-of-need controls.

##### a) Technical inabilities

Health planning agencies have had serious difficulty developing quantitative and qualitative definitions of community needs. This has resulted from inadequate sources of data and the relatively primitive state of the art of health planning. They have also had a clear lack of technical expertise to evaluate the fiscal implications of capital expenditure proposals. These inadequacies have often led to a decision-making process that involves more community politics than objective analysis. As a result, prestigious and politically powerful, though not necessarily more efficient, providers often benefit from the review process, sometimes at the expense of less prestigious and perhaps more efficient providers. Without objective standards or data to evaluate provider claims, particularly of improved quality, HSAs are reluctant to question such assertions.

b) Lack of incentives for effective review

Local HSA boards lack political or economic incentives to turn down capital expenditure proposals. Local political pressure is strongly in favor of expenditures, especially those that are promoted as creating improvements in medical care quality or access or providing local jobs. Since the costs associated with building or operating the proposed projects will be covered and "hidden" through our present reimbursement mechanisms, even HSAs which appreciate the ultimate impact on total costs feel no direct economic pressure to make local denials.

c) Lack of competition in review process

In general, certificate-of-need laws require HSAs to respond to capital expenditure applications only as they are submitted by providers, and then to finish the review within a specified time limit. This forces the HSA to act under pressure and provides a distorted incentive for providers to be first with their applications. Hence, in-depth planning and analysis of need may be precluded, for both the providers and the HSA. Unless all applications for similar capital construction proposals are received at the same time, the HSA is severely limited in its ability to compare the proposals on a competitive basis. This timing problem can also lead to excess approvals, since it is difficult to turn down a request from a major medical center for the same type of equipment that was approved earlier for a lesser facility.

d) Lack of control over incremental expenditures

In general, current minimum standards require certificate-of-need approval for projects which cost in excess of \$150,000, increase bed capacity, or provide new services. The focus is on identifiable major projects that increase service capacity. This allows hospital administrators leeway in creatively masking incremental expenditures that do not directly impact service capacity individually, but do so in sum. Of particular importance are "small" expenditures for modernizing facilities that do not increase service capacity but do increase per diem costs.

Strategies for increasing the efficacy of certificate-of-need review.

Three different, though not mutually exclusive, strategies can be pursued at the federal level to increase the efficacy of certificate-of-need review. The first two strategies center on improving the certificate-of-need review process itself. The third strategy is a more comprehensive approach aimed at controlling total health care costs, taking into account the relationships among various cost-influencing factors.

a) Incremental changes.

The law could be changed or implemented in a way that stresses a more analytical planning and review process. The level of federal



technical assistance to the states and local HSAs could be increased through staff training programs and dissemination of analytical techniques to analyze and evaluate project applications. Objective planning priorities, such as the proposed National Guidelines for Health Planning, could be issued at the federal level, and states could be required to establish definitive standards on a statewide basis. These changes would lessen the HSA's vulnerability to provider influence and might help reduce the amount of decision-making which is based on political considerations.

To deal with the time framework which precludes competitive reviews, legislative changes should require standardized review periods, wherein all applications for similar capital expenditures would be considered simultaneously as proposed in HR10460. For new and unforeseen technologies a study or waiting period could be required prior to acceptance of applications for review. This would allow time to gather reasonable indicators of utilization and medical benefits, perhaps based on trial projects in the HSA area. This could prevent a repetition of the recent national experience with computerized tomographic (CT) scanners, where a new, expensive technology was incorporated into routine practice before its effectiveness or usefulness was understood.

To control incremental expenditures, legislation could reduce the current maximum expenditure permitted before certificate-of-need review is required, or allowable expenditures could be scaled across time. For example, up to \$150,000 in expenditures could be allowable in one year, \$200,000 over two years, and \$250,000 over three years. Such limitations would reduce the likelihood of providers breaking up expenses incrementally to avoid certificate-of-need review. Certificate-of-need review could also be extended to encompass modernization expenses that do not influence service capacity.

b) Total capital expenditure limits.

As an incentive for more stringent review, legislation could be implemented to force certificate-of-need review to operate under a fixed total capital expenditure limit, as proposed in the Administration's cost containment act. Because fewer projects are likely to be approved under such a limit, the HSA would be pressured to justify why one project was accepted and another not. Indirectly, the need to justify projects would be an incentive for increased analytical back-up for decisions. However, an expenditure lid would increase the pressures on providers to be first with their applications, or to attempt to avoid review by making incremental expenditures. Hence, some of the methods discussed above for countering such pressures should complement an expenditure lid.

c) Interregulatory cooperation.

This strategy assumes that total health care costs will continue to grow rapidly even if certificate-of-need is effective in controlling



capital construction levels, since it will not be effective in controlling the non-capital component of per diem costs or in controlling the utilization of existing services and facilities.

Each of the areas where certificate-of-need is ineffective can be attacked by other regulatory agencies. Professional Standards Review Organizations (PSROs) can address utilization levels. Rate setting agencies can attempt to limit per diem costs, particularly non-capital costs. At least in theory, planning and certificate-of-need, utilization review, and rate setting all taken together should be able to slow the growth of health care expenditures. Whether they can have that impact in the real world, we do not yet know.

Cooperation with PSROs and rate setting agencies is likely to greatly improve the HSA planning and review process. PSROs can provide planners with qualitative and quantitative measures of facility utilization. When used in conjunction with PSRO standards and norms for quality care this information can greatly increase the ability to assess and evaluate the need for new facilities and services. Rate setting agencies have the type of staff who are knowledgeable about capital financing and can assist the review process by providing technical assistance to the HSA. Together these cooperative contributions on the part of PSROs and rate setting agencies can greatly improve the review process by making it more analytical and less political.

Cooperation between rate setting agencies and health planning can help to alleviate additional problems. In particular, if rate setting agencies agree with planners on appropriate levels for capital expenditures, the political cost of capital expenditure limitations will be diffused between the two agencies, benefiting both. Rate setting agencies generally require hospitals to formally project capital expenditures in advance. This budget information can increase the competitive nature of certificate-of-need review by permitting reviewers to compare all similar projected capital expenditures on a more in-depth basis at the same time. Finally, because of the budgetary process underlying rate setting, rate setting agencies are in a position to identify incremental increases in capital or service expenditures which might go unnoticed by certificate-of-need reviewers.

These cooperative relationships can provide mutual benefits. If services and facilities are in excess supply, the PSRO faces tremendous provider pressure not to limit utilization of the facilities or services. HSAs can augment PSRO utilization control by limiting the supply of facilities and services. HSA and PSRO quantitative and qualitative definitions of need can reduce the political weight of rate setting decisions to deny changes for existing unnecessary services or facilities.

Cooperative relationships between PSROs and rate setting agencies can also improve the efficacy of each organization. PSRO utilization data can improve budget forecasts and facilitate comparison of facility or service utilization/cost ratios. Rate setting limits on reimbursement for medically unnecessary care can increase PSRO impact.

If this strategy of interregulatory cooperation is pursued, legislation should center on increasing the incentives for cooperation. As a first step, confidentiality constraints on PSRO data-sharing have been loosened to permit HSA access to some measures of hospital utilization and need. (See our earlier discussion.) As a second step, financial incentives (perhaps in the form of federal subsidies for operating costs) might be provided for states to link rate setting agencies with SHPDAs, HSAs, and PSROs.

##### 5. De-certifying facilities and services.

As discussed above, certificate-of-need programs regulating capital construction suffer from a number of weaknesses which limit their ability to impact on health care costs. Some of these, such as the inability to control the number of units of service or the reimbursement rate, require coordination with other regulatory schemes and cannot be dealt with simply by altering the certificate-of-need program. One major weakness, which can be addressed by modifying the federal planning law, is the inability of certificate-of-need programs to reduce unnecessary components of existing fixed institutional costs. Making continued certification of facilities and service contingent on periodic re-evaluations of need would help fill this loophole. It needs to be recognized, however, that it is very difficult politically for government to close hospitals, no matter what the law authorizes, and that any decertification should also involve measures to minimize unnecessary disruptions in medical practice patterns.

Should unneeded facilities and services be decertified? Services which are underutilized contribute to total costs because higher prices must be charged to cover the fixed costs of keeping the unit in operation. In general, when facilities or services are utilized at such inefficient levels they should be cut back or eliminated. The relationship between costs and other criteria of need is not so clear-cut, however. For example, if a facility is considered inappropriate because of its location, it may be more costly to close it and build another at a more suitable location than to keep the existing facility open. From a cost containment point-of-view, "unneeded" or "inappropriate" determinations should lead to cutbacks or elimination, but only when such measures would lower total long-run costs.

Two mechanisms for dealing with unneeded facilities have been proposed and at least one state has implemented them both. One approach is to tie continued licensure to determinations of need. The other is to base the rate of reimbursement on appropriate, rather than actual, utilization. Each approach has its merits and problems.

Decertifying, or refusing to reissue a license, is the most direct way to eliminate unneeded facilities. Its main weakness is that it requires identifying specific institutions or units to be closed or cut back. The experience to date in New York illustrates the political difficulties involved in trying to shut down an operating hospital. In addition, singling out institutions for closure raises legal questions about compensating bondholders, proprietors and other creditors who would otherwise suffer financial losses. Another serious problem is the impact of such cutbacks on physicians in areas where medical staff privileges are restrictive and disruptive of services to some groups.

Gearing the reimbursement rate to appropriate utilization levels provides an indirect sanction that sidesteps some of the political problems inherent in decertification. If objective utilization criteria are applied to all institutions and reimbursement rates are set accordingly, an inefficient institution has the option to remain open running a deficit or cutting back services. This puts the decision in the hands of the institution's administrators rather than the regulatory authorities. To the extent that an institution cannot operate on a long term basis under deficits, it will eventually be forced to cut back services or close depending on the degree of inefficiency. One problem with this approach is that some institutions are probably strong enough to survive over long periods with deficits. Another problem is that institutions that are reimbursed below their costs may artificially increase utilization, or may attempt to skim low-cost care patients to subsidize losses. Hence, utilization review by PSROs or other bodies should be closely linked with rate setting mechanisms.

In spite of the problems, however, both sanctions should be applied if determinations of need are to be a central cost-containment strategy. Without such power, periodic reviews for appropriateness or need can only have an impact over a very long time frame. Certificate-of-need agencies could ultimately refuse to allow remodeling or replacement, but this would allow excess capacity to continue contributing to higher health care costs and reduced quality of care for many years.

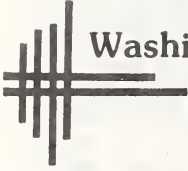
How should such a program be structured and administered? Effective sanctions to reduce excess capacity will require participation at all levels. To promote objective and equitable determinations which will serve broad interests, priorities and guidelines for appropriateness should be issued on a national and statewide level. While one might argue with the specific numbers selected, or the attempt to fix some standards on a nationwide basis, recently proposed versions of the National Guidelines for Health Planning are examples of the specific policy choices which should be made.

Once the framework for evaluation is established, local review is absolutely necessary. There needs to be some flexibility to allow for local variations because of the impact of such closings on factors beyond medical care costs. Access factors, notions of quality, and

even seemingly irrational local preferences must be addressed at planning hearings at the HSA level. Plans for institutional closures should take into consideration the provision of substitute services, the relocation of affected personnel, and the financial losses that will result. This process would be provided for in the Health Systems Plans and Annual Implementation Plans, carried out through the periodic appropriateness reviews.

Final licensure decisions should be made on the state level. This is a traditional part of state police power, and should be coordinated with other state regulatory and planning activities. Continued appropriateness or necessity would be a criterion of relicensure as is currently the case with life-safety standards.

Reimbursement rate decisions could be made at either the state or federal level. Minimum utilization rates might be adopted for calculating Medicare and Medicaid reimbursement on the federal level. States should be free to set more stringent levels if they wish, and there should be allowable exceptions for facilities which are needed for other reasons.



## Washington Business Group on Health

STATEMENT BY

The Washington Business Group on Health

on

H.R. 10460

*Health Planning & Resources Development Amendments of 1978*

Presented to the

Committee on Interstate and Foreign Commerce  
Subcommittee on Health and The Environment

U.S. House of Representatives

February 1978



The Washington Business Group on Health (WBGH) appreciates the opportunity to submit testimony on the Health Planning & Resources Development Amendments of 1978 (H. R. 10460). As the Appendix identifies, the WBGH enjoys active participation by 150 large industries. This list does not show that these firms provide health and medical benefits for more than 30,000,000 employees, retirees, and dependents.

We are convinced that health planning can work, and we therefore endorse strengthening and improving the health planning law.

#### Why Business Supports Health Planning

The WBGH supports the health planning system.

We want to assure you that we do not take our position casually or base it upon naive hopes. No system which is national in scope and comprises hundreds of new organizational entities will be perfect. No matter what amendments are passed, 10 years from now those who would rather see planning fail will be able to present isolated horror stories to support their position.

We do not want to see planning fail. As business people, we have taken the position that the only responsible way to make health planning truly reflect our local needs is to make a major commitment to working within the system for its improvement and implementation.

Business supports health planning for several reasons:

1. if properly conducted, it is local planning
2. the rising cost of health care, of which we are all so well aware, forces us to look inside the system for changes. This is especially true at a time when so many of our nation's resources are increasingly limited. It is inconceivable to business people that a \$160 billion segment of our economy would or should be totally devoid of planning. The waste in our health system costs us billions of dollars annually which could otherwise be applied to our very real health needs.
3. As private businessmen, we desire to keep our health system in the hands of the private sector to the greatest extent possible. We believe long-term solutions can only be achieved by a cooperative

effort of the public and private sectors. The Health Planning System is a vehicle to work together toward our common objectives.

4. It makes sound economic sense for business to become directly involved with the HSA. No matter how much our individual companies spend on health benefits and programs, in most locations we do not have the size and strength to reorder the delivery system by ourselves. Therefore, and quite appropriately, we must work with labor, with other employers, with local government, and, especially, with the providers.

The Summit-Portage County HSA represents a good case study of the accomplishments which can be derived from health planning with strong support from the corporate community. Financial support has been received from the local rubber companies.

The following chart shows the results of the HSA Project Review Process:

August 1974 to February 1977

HOSPITALS	30 PROJECTS
Total	\$121,346,332
Approved	52,785,332
Disapproved or Withdrawn	68,561,000
LONG TERM FACILITIES	13 PROJECTS
Total	\$ 20,915,886
Approved	9,411,000
Disapproved or Withdrawn	11,504,886
OTHER SERVICES	
Total	\$ 543,000
Approved	543,000
Total Projects	\$142,805,218
Approved	62,859,332
Disapproved or Withdrawn	79,945,886

Although the HSA's primary function is frequently viewed as saying NO, substantial savings can be made even when all agree that expansion is needed.

A 600-bed hospital received approval for a major modernization and expansion project. The HSA and hospital worked together for one year to jointly plan for this needed project. An agreement was made that the hospital would reduce manpower by 63 full-time

equivalents in 1979 and reduce the average length of stay by one day.

*Result:* Savings of \$7,750,000 over a 10-year period

Public attention is drawn to the capital expenditures that receive or are denied HSA approval. However, in the long term, it is often the project financing method which produces the greatest cost -- or saving.

A 500-bed hospital proposed construction of an Ambulatory Care Center at a cost of \$7,127,000. The proposal included refinancing of current debt as well as the new debt at 9.75 per cent interest. The HSA negotiated with the hospital to investigate financing alternatives. The hospital withdrew the project and developed a new financial plan which did not include refinancing of current debt and scaled down the project to a cost of \$6,733,000.

<i>Result:</i> Capital saving	\$ 394,000
Dollars saved over 10 years due to new financial plan	\$12,000,000

The hospital has also agreed to provide the HSA with the following:

- A quarterly report on construction progress and costs
- A quarterly report on utilization of services
- A total construction cost that will not exceed \$6,733,000
- A progress report on efforts to reduce the average length of stay by one day by 1978

5. Finally, *we support planning because we know it can work.* No, it will not work everywhere or in every instance. However, we have seen planning make, in its very short life since P. L. 93-641 was signed, substantial progress. We look at the alternatives and we see only two: Chaos or ever more stringent government controls. Neither is acceptable. Both can be avoided.

#### Why the HSA's Want Business Participation

After a period of skepticism, the WBGH is now being deluged with requests by HSAs for assistance in obtaining business participation. The reason for

this new interest is simple: those HSAs with strong business participation have found that the business people are, in general, excellent consumer representatives. Business can and should sit with Labor as vocal consumer advocates. Business brings to the HSA management expertise, potential financial support, technical back-up by the company in such areas as computer services and economic analysis, and the business people working on an HSA can serve as the natural conduit to other employers in the community.

#### RECOMMENDATIONS

We offer a variety of recommendations some of which are general while others are keyed specifically to H. R. 10460.

1. Cost-effectiveness should be specifically stipulated as a criterion for certificate-of-need review. We are concerned with the reports that HMOs and other forms of pre-paid group practices are being unduly restricted because their potential for cost effectiveness does not receive adequate consideration.
2. We support an increase in the consumer majority on HSA boards. While there is no perfect number, reports from HSAs indicate that the current 51% frequently is not reflected in decision-making meetings. As business and labor increasingly are asked to participate, we do not desire to replace any other qualified consumers or to create a false division between business/labor consumers and unaffiliated individuals who are also serving as consumers.
3. The planning process should cover all acute care facilities including government hospitals. The fact that their patient population may come from a broader area than the HSA jurisdiction, should be considered, but should not be an excuse for total exemption from the planning process.

Similarly, we support section 218 (a) requiring certificate of need to include review and determination of need for major medical equipment, health care facilities, institutional health services, home health services, and capital expenditures.

4. We support amending section 1515(b) to extend the permissible period of conditional designation from 24 to 36 months.

5. We do not support uniform cost accounting but do support uniform reporting systems.
6. We want to go on record in support of continuing and, indeed, strengthening the Centers for Health Planning.
7. We strongly endorse the establishment of formal linkages between planning programs and community mental health programs. To this end we support title V of the Health Services Amendments Act of 1978 (H. R. 10553) as it assures planning for mental health services and facilities, will become an integral part of the planning process established by the Nat'l Health Planning and Resources Development Act of 1974 (P.L. 93-641).
8. We oppose any legislative mandates concerning the categories of public officials or providers which must serve on HSA boards.
9. We support fully funding the HSAs at their authorized levels.
10. We support the development of HSA representation for insurance carriers. The third party payment system has a tremendous impact on every aspect of our health delivery system. To obtain the most value from the insurer's participation, they should not be categorized as either providers or consumers. Furthermore, we support section 208 (Amends §§ 1512 (b)(5) and 1516 (b)(2)(B)(1)). Insurance companies as well as other community interests should be able to offer funding to an HSA provided that an inappropriate proportion of assistance does not come from a single source.
11. Section 215 (amends section 1512(a)(2)(A): We support including financial and economic analysis and the prevention of disease and other public matters as required HSA staff skills.
12. Section 209 (d)(1): We support permitting the 12-month lead-time to be dropped for indirect provider participation as a consumer on an HSA board. Additionally, we support removing the 12-month waiting period for providers who by definition become consumers for the purposes of board membership.



13. Section 209(a) (amends section 1512 (b)(3)(C)(i)): the WBGH supports stipulating that labor unions be included as major purchasers of health care along with employers.
14. Section 213(a) (amends section 1512 (b)(3)): We endorse the provision that requires each HSA to have an identifiable program providing assistance to the members of its governing body, and the development of a study which would identify the needs of the members, particularly consumer representatives, in the areas of training and continuing education.

We would note for the record that several corporations are now conducting such programs and that the WBGH has worked with Boston University's new Center for Industry and Health Care to establish an on-going seminar program with the same educational goals.

#### CONCLUSION

We appreciate this opportunity to express our support for the health planning system. Our comments have been limited to planning but we would not want to leave the impression that we feel planning is THE answer to our health care problems. It is but one element of a vast and complex set of changes which must occur in order to attain a system of rational economic incentives, which includes: access for all to needed, appropriate, affordable quality care; health education on a scale never previously contemplated; and acceptance of the need for life-style modifications.

Planning, we would submit, will be a central element of any effort, public or private, to achieve that common objective which we alluded to at the start: *A better health care system for all Americans.*

Thank you.

H. R. 10460HEALTH PLANNING AND RESOURCE DEVELOPMENT AMENDMENTS OF 1978

To: Representative Paul Rogers, Chairman, and members of the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, U. S. House of Representatives.

Testimony of Julian J. Knox to:

HEARINGS on Proposed Amendments to Titles XV and XVI of the Public Health Service Act. (P. L. 93-641).\*

It gives me great pleasure to have this opportunity to give testimony to the Subcommittee, in the development of legislation for Health Systems Agencies (HSA) and Statewide Health Coordinating Councils (SHCC).

I am a Service Fellow in the National Center for Health Services Research, Department of Health, Education, and Welfare and a Scholar-in-Residence, National Library of Medicine, National Institutes of Health. I am currently undertaking a study of ways in which consumer members of HSAs and SHCCs are addressing the tasks of effectively incorporating a community voice and contribution to planning local and state health systems. This study, which was commenced in June, 1977, has so far included interviews

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\* The views expressed in this Testimony are those of the writer and not necessarily those of either the National Center for Health Services Research or the National Library of Medicine.

with some sixty consumer board members, extended visits of observation to seven HSAs and one SHCC including consultation with professional staffs and provider members of the boards; interviews with groups representing special interests (eg. parents' groups, mental health associations, organizations for the elderly, etc.) and written correspondence with, to date, forty-five executive directors of HSAs and twenty directors of State Health Planning and Development Agencies (SHPDA).

During the past twelve years I have been concerned with many aspects of consumer or community participation in health services, urban planning, and organizational development; in France, where I was Professor in the École Pratique des Hautes Études (Sorbonne), and consultant to the Commissariat-Général du Plan, de l'Équipement et de la Productivité (The French National Planning Agency under the Office of the Prime Minister); in London, where I was a senior staff member of the Tavistock Institute of Human Relations (social policy program); at Georgetown and Yale Universities, where I was a Visiting Fellow studying consumer boards of neighborhood health centers and community mental health agencies. From 1974 to 1977 I was Secretary of the Community Health Council, Islington, London.

## INTRODUCTION

Public Law 93-641 established agencies in health care planning at local and state levels in the form of Health Systems Agencies and Statewide Health Coordinating Councils. The planning boards of these agencies are composed of consumers and providers with the consumers having a majority. In many cases HSAs operate with sub-regional committees or advisory councils whose membership composition is usually the same. They also undertake some of their work, such as Project Review, Certificate of Need assessment, and

Plan Development through "standing committees". HSAs relate to distinct geographical and usually political areas. Implicit in the organizational framework of the Act is the general goal to bring providers and consumers into an equitable partnership to produce plans aimed at meeting the comprehensive health care needs of the local population.

Much of U. S. experience of consumer participation in health care planning has shown that, in reality, the "partnership" is almost always an unbalanced one. Providers and health professionals usually have well-organized institutional and professional structures and have the facility to form strong coalitions to exert pressure for furthering particular interests, while the consumers do not.

The majority of consumers on these boards are not working with the support of distinct constituencies of local interest, for few communities have developed high levels of awareness regarding comprehensive health care, and many people do not realize that they are, in fact, represented on local planning boards. Currently, community organization around local health issues is rare and there is little effective articulation of concerns and priorities. Consumer board members tend to have highly individualistic perceptions of community needs, and there are few opportunities for them to accumulate substantive knowledge of community experience and reactions. At meetings, the views of consumers are often successfully challenged by providers (and sometimes by the professional staff of the HSA) to the point where even important questions, albeit badly framed, are scornfully discarded.

The various methods employed for appointing consumers to HSAs and SHCCs have tended to militate against true democratic

representation. Nevertheless, in whatever way the present consumer members of boards were chosen, and notwithstanding the current crop of actions challenging appointments, the fact remains that throughout the country there are ordinary people legally representing their communities. While more equitable mechanisms for selecting consumer board members will no doubt be established, much can be done now to assist those who are already appointed.

It is crucially important that structures of accountability be built between the community and HSA consumer members, and that a clearly defined community-based component of health services planning be ensured. This would permit the community to set its own priorities and preferences and develop its own agenda, uninhibited by constraints implicit in traditional provider-dominated planning and administration.

Facilitating Community Representation and Participation Through Training and Resources (Reference: H. R. 10460, Section 213)

Many of the training and educational programs offered by government and other agencies overlook the special needs for skill development of consumer members of HSAs and SHCCs. These skills include those which pertain to health planning procedures and also those which assist a lay, often inexperienced, group to obtain a clear voice in decision-making. (Some community people assume the stance of "activist" but lack the effective follow-through, while others, through shyness, or as a result of continued "put-downs" or perhaps deeply felt frustrations, hardly speak at meetings and would make Uriah Heep seem forthright.) Some training and education programs virtually exclude the consumer due to inconvenient scheduling. Many consumers have been critical of those courses which emphasize the assimilation of consumers into the planning process rather than the adaptation of the process to



community inputs. This problem is one which is neither confined to the U. S. A. nor to health services planning which, itself, has borrowed much from other planning domains, especially urban development. Health planners are not alone in this dilemma, and they often find it easier to maintain old traditions of decision-making. These, of course, are not amenable to "community participation" (eg. "the most efficient decisions are those made by the smallest number of people").

HSAs need to develop a community methodology which will provide a balanced and comprehensive appraisal of the nature, significance status, and merit of information and proposals, and in the case of policies and innovations, predict their impact with a reasonable degree of probability.

The need for programs to be directed specifically to consumer skill development has been long recognized, but fears of creating divisiveness between consumer and provider board members seem to override efforts to fulfill this need. Similar inhibitions have affected the deployment of HSA staff to specifically assist consumers in developing their potential. Many HSA executives are convinced of the need to provide a framework for community participation and to include community priorities and preferences in planning, yet are uncertain as to how this can be accomplished. This is not so much a fault of HSAs, rather, it is a general failure to develop planning paradigms which permit flexibility and recognize that politics is an essential element of planning.

There is clearly a case for assigning to HSA staff the role of working exclusively with the community and with their board representatives, and these "community specialists" should report directly to consumer members. In cases where HSAs have already

assigned staff members to "work with the community", the staff is still subject to the consumer/provider configuration of the agency as a whole, and also to the technical demands of planning and administration. This creates problems, not least those of divided effort and loyalty.

It must be added that some of the needs of consumer board members are simple and practical. They include secretarial and administrative assistance which provider members obtain from their own organizations as a matter of course. Another aspect is the absence of some form of reimbursement to consumers for the loss of work time. Also, unlike the providers, very few consumer members have good channels of information about up-coming issues in state and national legislatures.

In short, we need to provide consumer board members with techniques for transforming themselves from a common state of apathy, confusion, and powerlessness, to being a vital constituent of local planning. This would undoubtedly bring about some conflicts within the HSA, but there exists a range of strategies which can be utilized to transform conflict into productive outcomes and lead to mutually satisfying negotiations between providers of health care services and the communities they serve.

## GENERAL COMMENTS ON SOME H. R. 10460 PROPOSALS

I have a number of comments regarding specific proposals set down by the House Bill 10460, Senate Bill 2410, and the Draft Administration Bill. These are as follows: Personnel Rules and Budget, Changes in Representation on HSA and SHCC Boards, and Dual Membership of HSAs and SHCCs.

I. Personnel Rules and Budget (Reference: H. B. Section 211)

I believe it would be a backward step if the responsibility for personnel rules and HSA budget were to now shift to a governing board composed mainly of public officials. The topics of staffing and the management of the agency's money are already matters of considerable concern to consumer members, and this proposal seems to remove an important and fundamental right of consumer members to participate in the running of their agency. There is ample evidence from the British experience that community representatives accept these responsibilities most seriously and make valuable contributions to decisions about staff and budget.

II. Changes in Representation on HSA and SHCC Boards (Reference: H. B. Section 209, S. B. Section 110, A. B. (d) Section 204)

a) The proposed amendments revise, to some extent, representation by both providers and consumers. I believe it is most important that labor organization representatives be appointed to governing bodies; not only from organizations which are major purchasers of health care services, but also from trade union organizations whose membership includes non-medical, non-nursing staffs. Whether the latter should be placed in a special category with an option for selection, or introduced as a statutory category of provider, needs to be studied closely. In the British system, non-medical (ancillary) hospital and community health services employees have the right to nominate representatives to both the Area Health

Authorities (AHA) and the Community Health Councils (CHC). It should be stressed that in respect of CHC membership, there is no bar if the community or a local interest group nominates a health professional, administrator, or paraprofessional, and while informal "conflict of interest" safeguards do operate, there have been very few significant problems. Furthermore, many CHCs "co-opt" (ie. cooperate) local health professionals to informal subcommittees, and it is not uncommon to see the chief of a medical service, a senior nurse, a medical social worker, and a ward aid as members of CHC task forces or working parties. Many health service workers have the added advantage of both working in the service, often "at the shop front", and also living in the close neighborhood. The information and knowledge which they bring to the CHC and also to management and planning are of particular value and are complementary to existing structures for joint staff consultations.

Many aspects of the selection and appointment procedures for HSA and SHCC members - whether they be consumer or provider members - have shortcomings, not least those of artificiality. The concerns regarding the equity of consumer appointments have been voiced generally, but there are also problems regarding provider appointments. Perhaps this is due to the remoteness of the HSA from the operations of health care services which is largely a consequence of planning and management being divorced from one another. The HSA is still heavily institution-oriented rather than system-oriented, and its plans are developed around service monitoring rather than assessed outcomes. This suggests that provider appointments should be drawn more from people working in the field, and particularly from those involved in growing inter-agency arrangements for the provision of health care and social services. Certainly the public health nurse and the social worker, being trained observers and epidemiologically oriented, have more pertinent information about the state and needs of the population than do the solo-practice podiatrist, chiropractor, dentist, or even that rare

bird, the family physician.

b) In the House Bill proposed Amendment, Section 209, consumer representation is amended to include members who were not direct providers during the preceding twelve months. While this is clearly aimed at allowing former consumer members of neighborhood health centers of HMO boards to serve on HSAs and SHCCs where, under previous legislation, they could not except after a protracted period, it still does not permit a body of consumer board membership drawn from the widest reservoir of active and knowledgeable community representatives. The Senate Bill Section 110 deletes the requirement that a consumer not be a provider during the preceding twelve months, and since much of the criticism of consumer representation on HSAs has centered upon members' inability to function effectively in committee, and in regard to discussion and development of technical work and proposals, it would seem desirable that, as far as possible, encouragement be given to recruit community people who have practical knowledge of local health provisions and issues, experience in decision-making and management, and above all, who are accustomed to being accountable to local constituencies.

### III. Dual Membership of HSAs and SHCCs

Many HSA consumer board members are now becoming members of SHCCs. In some cases, they are resigning their HSA memberships which means that the HSAs are losing experienced and knowledgeable people at the time when they can least afford it. In other cases, the HSA member is serving on both boards, and there are already signs that this dual commitment is proving too demanding upon the individual, and resignations are expected. Dual membership would also lead to possible conflicts of interest. For example, the HSA member who is also a SHCC member assumes a part of the corporate responsibilities for both a Health Systems Plan and an eventual State Health Plan. The State Health Plan is made up of the HSPs of



the HSAs within the state, and it can be assumed that one of the expected responsibilities of the HSA/SHCC member is as advocate of his or her own HSA's planning proposals. But once the State Plan is ratified, the dual member could be precluded from continuing to advocate local concerns in cases where there were differences over priorities between the state and local HSA. This was one of the main reasons why, in the British National Health Service Reorganization, Community Health Council members were given observer status on Area Health Authorities rather than voting membership.

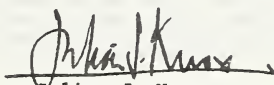
#### NOTE ON COMMUNITY PARTICIPATION IN THE BRITISH NATIONAL HEALTH SERVICE

Members of the Subcommittee will be aware that, under the National Health Service's Act of 1973, the United Kingdom Government institutionalized community representation at the levels of Regional and Area planning and management. In addition, every Health District (the basic unit of planning and management) is required to have a Community Health Council (CHC). The members of CHCs are nominated and appointed from a community base of 50% local elected officials or their representatives and 50% local interest groups who organize their own election, selection, or nomination processes. The CHCs are not incorporated into the management structure of the National Health Service, but they have legal rights of access to information and health care facilities. Their one formal power is that of veto over management proposals which affect changes in type and level of provision, and they are also required by law to be consulted over planning proposals and both general and particular aspects of policy. They have observer status at meetings of Area Health Authorities (AHA) and are an input from the community which is additional to that provided through elected members of the AHAs. Members of CHCs also

represent their communities on Health Care Planning Teams (HCPT) at the District and Area levels.

It can be seen, therefore, that the British Community Health Councils provide their communities, on the one hand with a forum for discussion of local health care and health-related services concerns, and on the other hand with an institutionalized resource to assist them in presenting their needs and aspirations, as well as critique of services, to the managers and planners of the NHS. At a practical level, of course, the CHC provides the community with technical resources for monitoring services and needs.

I shall be most happy to answer any questions raised and provide further information which may be required regarding this Testimony. I wish to place on record my thanks to the National Center for Health Services Research and the National Library of Medicine for providing me with the opportunity to study the contemporary American arrangements for health services planning.



Julian J. Knox  
Scholar-in-Residence

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National Institutes of Health  
8600 Rockville Pike  
Bethesda, Maryland 20014

February 1978



# mental health association

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national headquarters

January 31, 1978

Honorable Paul G. Rogers  
Chairman  
Subcommittee on  
Health and the Environment  
Room 2407  
Rayburn House Office Building  
Washington, D.C. 20515

Dear Mr. Rogers:

I wrote to you January 26 requesting opportunity, on behalf of the Mental Health Association, to present testimony of H.R. 10553.

Some of our testimony on that legislation will have implications for H.R. 10460. While we are not testifying on H.R. 10460, I did want to state for the record and in anticipation of our subsequent testimony that we will be recommending changes in certain of the sections of P.L. 93-641 under consideration in H.R. 10460.

The Mental Health Association strongly supports the concept of integrated health planning with an identifiable mental health component. We therefore will generally support H.R. 10553 and express our appreciation for the introduction of this forward looking piece of legislation, in which for the first time this concept would be clearly articulated in law.

For reasons which we will develop in our later testimony, we believe the amendments to P.L. 93-641 should include a requirement that the state authorized mental health planning be incorporated as an identifiable component within the Health Systems Plan and Annual Implementation Plan. We further believe that the state health plan approved by the State Health Co-ordinating Council should be required to include the state authorized mental health plan unless that plan and the planning process underlying it is not consistent with the provisions of P.L. 93-641.

## NATIONAL OFFICERS 1978

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We are greatly encouraged that the concept of mental health representation has been recognized in H.R. 10553. We believe this concept should be strengthened by adding a requirement that a significant proportion of the providers and consumers at both regional and state levels, as well as professional staff at both levels, be mental health qualified.

Because we believe that state authorized mental health planning should be the basis of identifiable mental health components of regional and state health plans, we would further recommend that amendments to P.L. 93-641 incorporating the state mental health planning process in the Federal health planning legislation should mandate that citizen participation at local, regional, and state levels in the mental health planning process be consistent with and compatible with the representation required of the governing bodies of HSA's and SHCCs.

We will further testify that the Congress should incorporate in amendments to P.L. 93-641, or other relevant legislation, a clear statement of its intent that specific Federal funds be provided for state mental health authorities to develop and maintain on-going planning at regional and state levels. We will recommend that at least 80% of those funds be utilized for regional and local mental health planning purposes.

Sincerely yours,



Allan Moltzen  
Chair, National Committee on  
Legislation and Services

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February 2, 1978

Honorable Paul Rogers, U.S.C.  
Chairman  
Subcommittee on Health & The Environment  
2415 Rayburn House Office Bldg.  
Washington, D.C.

Attn: Jo Anne Glisson

Dear Congressman Rogers:

Attached you will find a statement prepared by the National Health Council, Inc. and the American Diabetes Association dealing with the Health Planning and Resources Development Act which is now under consideration in your Subcommittee. We would appreciate it if the attached statement could be included in the hearing record regarding the "Planning Act".

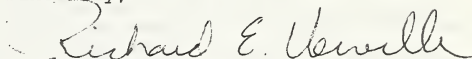
The problem which our statement highlights involves the definition of "indirect provider" in Section 1531(3)(B) and the effect which this definition has on membership in the governing body of the Health Systems Agencies ("HSA"). An indirect provider is defined presently as one holding a fiduciary position with an organization engaged in any way and in any degree with the provision of health care, health research or instruction. The result of this definition is that lay people, who are not otherwise engaged in the delivery of health care, who serve as volunteer members of the boards of directors of nonprofit health organizations such as the American Diabetes Association, are denied participation as consumers in the governing body of an HSA. However, these same individuals are perceived as consumers and not as representatives of providers in their locality and as a result cannot obtain provider positions on HSA boards. In fact, these individuals are perhaps the best example of consumers because they are active in



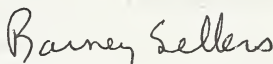
health consumer movements and have knowledge of the health care system. They are not, however, practising in the field of health care or receiving financial remuneration for their participation on these boards of voluntary health organizations and these voluntary health organizations are not primarily engaged in health care delivery, research or instruction. They are clearly not organizations which form, in any way, a major part of a local health care system.

We thank you for your consideration of this issue. We hope that some change in the "Planning Act" can be made to encourage the participation of such individuals on HSA governing boards. The bill currently being considered in the Senate, S. 2410, does include a provision at Section 140 which would remedy the problem we have described above. We would hope that the House would pass amendments to the "Planning Act" which would also remedy this problem.

Sincerely,



Richard E. Verville, Counsel  
American Diabetes Association



Barney Sellers  
National Health Council, Inc.

REV:kh  
Enclosure

February 2, 1978

The Honorable Paul Rogers  
Chairman  
Subcommittee on Health & The Environment

Dear Mr. Chairman:

We would like to bring to your attention a problem under the 1974 Health Planning and Resources Development Act which affects several national voluntary health associations and their volunteers. As you consider reauthorization of the law, we would appreciate if you would review the issue in question.

The problem is the manner in which the definition of "indirect provider" has been applied to certain volunteers in health associations. Of particular concern to us is the impact on volunteers in the American Diabetes Association, the American Lung Association, and potentially others in our Council. Administrative interpretations of the statute have prevented volunteers -- who otherwise have no financial or fiduciary interest in the health system -- from participating, and in some cases, from being considered as consumer representative members on the boards of local or regional Health Systems Agencies. In our view, this interpretation is not consistent with Congressional intent nor the law. It prevents true volunteers and consumers, who are often the parents of crippled, diseased or disabled youngsters, and who perceive themselves as advocates for needy patients, from joining fully in the local planning process. To characterize these persons as providers, we believe is a distortion of Congressional intent, and is unwise. It has the practical effect, in addition, of placing these persons in a smaller, more

competitive category of Health Systems Agencies ("HSA") representatives who do not perceive voluntary health association members as appropriate representatives of providers.

The legislative history of the provision in question (Section 1531(3)) shows that the House and Senate agreed that certain restrictions should be placed on the participation of providers of health services in the local planning process. We do not quarrel with the intention, nor with its application to volunteers who, in their private lives or professional capacities, are otherwise covered by the definitions in question. During the conference, the House proposed a category of "indirect provider" intended to expand the basic definition of "direct provider". The conference report stated:

"A direct provider is an individual whose primary current activity is the provision of health care to individuals or the administration of health care facilities and who, as required by State law, has received professional training and is licensed or certified. Indirect providers are individuals who have certain fiduciary positions or financial interests, who are members of immediate families, or who are engaged in issuing health insurance."

The conference substituted the House amendment.

The statutory definition of a "provider of health care" states that a direct provider is "an individual [whose] primary current activity" is the provision of health care. An indirect provider is one who (a) has a fiduciary relationship with an entity engaged in providing care or "in such research or instruction", or an entity producing drugs; (b) receives "more than one-tenth of his gross annual income" either from the activities in (a) above, fees or research or instruction or for production of drugs; (c) is a member of the immediate family of

a direct provider; or (d) issues health insurance.

The voluntary associations we are concerned with are those created in response to needs for research, education, and -- in a few cases -- treatment for illnesses and diseases which disable, cripple and otherwise impair. These organizations are classified under the tax code as public charities and receive almost all their funds from public donations. Members of boards of directors of these groups are volunteers, and many are parents or relatives of persons who have been stricken with the particular disease or illness with which the respective organization is concerned. They serve with special commitment and knowledge.

The provision referring to fiduciary relationships is relied on by DHEW to reach a conclusion that members of the boards of directors of these types of associations cannot serve on local HSA boards as consumers (serving as providers is politically impossible) because these persons are "indirect providers". We believe that, with certain severe exceptions, such a conclusion is ill-advised, even if it can ultimately be supported by a technical reading of the statutory language. The exceptions ought to be where the individuals themselves are otherwise covered by the provider clauses; where the local chapter of the association itself is primarily engaged in the direct provision of health services and receives compensation therefor (although even here a reasonable argument can be made that persons on boards are still volunteers acting in the interest of the clients served by the association); and where the person is a paid officer or staff member of the association. We make no claim that a paid employee of a voluntary organization be

considered as a consumer.

The fiduciary interest clause applies where the entity is "engaged in the provision of health care or in such research or instruction;" or is "engaged in producing drugs or such other articles". It seems inconsistent with Congressional concern about undue financial dominance in the planning process to restrict the participation of volunteers from associations who support, through the distribution of publicly-donated funds, medical research by other parties. A reading that a volunteer director of such an association is a provider of health care with a financial stake in the system assumes conspiracy beyond the bounds of common sense. It ridicules the sincere and sometimes passionate interest that many volunteers bring to the cause with which they associate themselves -- on behalf of the patient suffering from the disability in question. To limit such persons in active participation stifles the enthusiasm, commitment, help, advice and involvement our health care system desperately needs. To define them as providers severely restricts the actual possibility of their serving since providers' positions are generally restricted to the typical health care provider: health professional, insurer, facility administrator. In addition, these volunteers who do not otherwise qualify as providers, the lay people who do not provide care or receive financial payment directly from its provision, are consumers and should function in that role. They are viewed as consumers locally and therefore cannot achieve provider positions.

We believe that a resolution of the problem should seek to do the following:



\*Clarify that private citizens serving on boards of voluntary associations classified under the tax code as public charities, except where a primary purpose of the health charity is to provide health services in the health systems area, should be permitted to participate as consumers on local HSA boards;

\*Clarify that these types of associations which distribute funds for biological medical and health services research, at both the national and local level, and do not primarily engage in research themselves, are not considered indirect providers under the applicable clause;

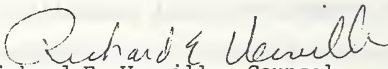
\*Clarify that for these charitable health associations the term "instruction" as used in defining "provider" does not include education of the general public or the association's members;


\*Clarify that private citizens serving as unpaid volunteers on boards of directors of these types of associations who otherwise would not be classified as direct or indirect providers should not be so classified solely because of their board membership status; and finally,

\*Clarify that the policies adopted should be applied uniformly across the nation.

Section 140 of S. 2410 would remedy this problem. A similar provision in House legislation would be welcome.

We appreciate your consideration of this question.

  
Richard E. Verville, Counsel  
American Diabetes Association

  
Barney Sellers  
National Health Council, Inc.



## OHIO STATE MEDICAL ASSOCIATION

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February 3, 1978

The Honorable Paul G. Rogers, Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
2407 Rayburn House Office Building  
Washington, D. C. 20515

SUBJECT: The Health Planning and  
Resources Development Act  
of 1978, H.R. 10460

Dear Mr. Chairman:

Having read with great encouragement and reassurance your remarks made when you introduced H.R. 10460 January 19, 1978, I respectfully request that this letter and its attachments be made a part of the record of the current hearings pertaining to that legislation.

The Ohio State Medical Association is a willing supporter of the position stated in your introductory remarks concerning what you so aptly describe as . . . "the need to strengthen local decision-making about new facilities and services," and your emphasis on the role of the States in developing . . . "programs which would assure that inappropriate services are not provided."

Those of us who have followed your development of local planning and resources development concepts through your original legislation, (the National Health Planning and Resources Development Act of 1974) know full well that your statements once again are a strong reiteration of the purpose and intent of the original Act, Public Law 93-641.

I remember being so heartened, when I heard you subsequently address the American Medical Association Leadership Conference, by your forthright explanation of the purpose and intent of your legislation. I was particularly pleased when you then explained, quoting from your address:

"Contrary to what some may think, it (the Rogers Act) doesn't place all the power in the Secretary because we wrote it where it wouldn't. We've put it in that local planning area, and we said we want direct providers on it, and we've protected the direct providers of health.

"And we give the basic decision to the local planning groups--people at home--people who are there with the problem, who know what's to be done. We don't sift it up to the Secretary. It's to be done there."

### DISTRICT COUNCILORS:

FIRST--STEWART B. OUNSKER, M.D., CINCINNATI  
FOURTH--C. DOUGLASS FORD, M.D., TOLEDO  
SEVENTH--ROBERT E. RHODENRICH, M.D., ZOVER  
TENTH--J. HUTCHISON WILLIAMS, M.D., COLUMBUS

SECOND--W. J. LEWIS, M.D., DAYTON  
FIFTH--THEODORE J. CASTELE, M.D., CLEVELAND  
EIGHTH--RICHARD E. HARTLE, M.D., UNCASSTER  
ELEVENTH--S. BAIRD PFAHL, JR., M.D., SANDUSKY

THIRD--ALFORD C. OLLER, M.D., CONVOY  
SIXTH--C. EDWARD PICHETTE, M.D., YOUNGSTOWN  
NINTH--THOMAS W. MORGAN, M.D., SELLVILLE  
TWELFTH--WILLIAM DORNER, JR., M.D., ARRON

You again reiterated the necessity for local decision-making authority by your statement January 30 in convening hearings on H.R. 10460, particularly in your reference to the revised guidelines announced January 18.

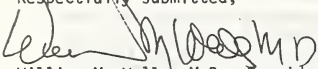
We share your clearly expressed dedication to preserving the independence of the local planning groups and the state agencies in carrying out the intent of Congress. I urge you to read the enclosed correspondence. It clearly illustrates the power-hungry attitude of HEW toward health planning.

We have reviewed your proposal (H.R. 10460) to strengthen your legislation. The need for it is clearly demonstrated by the fiasco of the regulations published in the Federal Register September 23, 1977, and the attitude and tactics of HEW as demonstrated in the enclosed correspondence.

Also, we have reviewed the amendments proposed by the American Medical Association before your subcommittee January 31, and we urge the adoption of those recommended amendments.

Thank you for your courteous attention. Please let me know if you have any questions or would like additional information.

Respectfully submitted,

  
William M. Wells, M.D., President  
Ohio State Medical Association

WMW:ii

cc: Congressman Clarence J. Brown  
Congressman Charles J. Carney  
Congressman Samuel L. Devine  
Congressman Thomas A. Luken

enclosures: Letter of January 17, 1978, from Health Resources Administration  
Administrator to Ohio Director of Health

Letter of January 30, 1978, from Ohio Director of Health  
to Secretary of Health, Education and Welfare

Letter of February 2, 1978, from President, Ohio State Medical  
Association to Secretary of Health, Education and Welfare

January 30, 1978

The Honorable Joseph A. Califano, Jr.  
Secretary of Health, Education, and Welfare  
Washington, D. C. 20201

Dear Mr. Secretary:

On January 23, 1978, I received a letter from a Henry A. Foley of your department criticizing actions of the Ohio Department of Health.

On January 20, 1978, copies of this letter were made available to the Dayton Daily News and to the legal staff of Blue Cross of Southwest Ohio.

A hearing was scheduled before the Insurance Commission of the State of Ohio on an appeal by St. Elizabeth's Medical Center against Blue Cross of Southwest Ohio. Attempts were made to enter copies of Mr. Foley's letter into the record at that hearing. At the time of the hearing, I had not yet received the original letter.

I am greatly disturbed, Mr. Secretary, that a responsible member of your staff would resort to such unethical behaviour in a flagrant attempt to influence and prejudice a legal hearing. I request some assurance that this type of action will not occur again, that proper disciplinary action be taken against Mr. Foley, and that I receive a written apology for the actions of your Department.

It is difficult enough to carry out our capital expenditures reviews without harassment and dirty tricks from HEW.

I will anticipate a speedy reply.

Sincerely,

John H. Ackerman, M.D.  
Director of Health

JHA/jv



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
PUBLIC HEALTH SERVICE  
HEALTH RESOURCES ADMINISTRATION  
HYATTSVILLE, MARYLAND 20782

OFFICE OF THE ADMINISTRATOR

JUN 17 1976

John H. Ackerman, M.D., M.P.H.  
Director of Health  
Ohio Department of Health  
450 East Town Street  
Post Office Box 118  
Columbus, Ohio 43216

Dear Dr. Ackerman:

The Health Resources Administration recently completed its review, pursuant to three requests for reconsideration under Section 1122(f) of the Social Security Act, of the capital expenditure proposed by the Kettering Medical Center for the purpose of constructing an affiliate hospital. Upon reconsideration, the Acting Administrator determined that Titles V, XVIII, and XIX reimbursement related to the capital expenditure will not be withheld under the authority of section 1122. A copy of the response to each reconsideration request was forwarded to you.

Serious and legitimate complaints have been made concerning the conduct of this section 1122 review performed by the Ohio Department of Health (the designated planning agency (DPA) for Ohio). Although there is no statutory basis for applying a sanction against the proponent of a capital expenditure because of an error by the DPA, I feel it essential to the integrity of the section 1122 program that the defects of this review not be repeated in the future.

I find the following aspects of the review particularly troublesome:

1. In your letter of May 17, 1976, to Mr. Stephen F. Davie, Executive Director of the areawide health planning agency, you stated that approval of the two projects (Kettering and St. Elizabeth's) would "definitely add more medical/surgical beds to the Dayton area than are indicated in the current Hill-Burton bed need projection."



Congress clearly required, in section 1122(b), that the Hill-Burton plan be included among the standards, criteria, and plans for reviewing proposed capital expenditures. The submission to the Department of Health, Education, and Welfare of findings of conformity for the two projects, when at least one proposal was not in conformity with the Hill-Burton plan, is strictly inconsistent with the terms of the section 1122 agreement between this Department and your agency, as well as the goals of the health planning program generally. Although I am prevented by the statutory language of section 1122 from requiring you to reconsider your action on the Kettering proposal, responsible health planning would have precluded the action of approving the two expansion projects contrary to the need specified in the health plans.

2. In your letter of May 17, 1976, to Mr. Davie, you explained the reasons for your positive findings and recommendations concerning the Kettering Medical Center and St. Elizabeth Hospital proposals. Among these were that the Kettering Medical Center had agreed to your request to "(1) reduce the cost and size of the proposed facility, (2) operate within the current reimbursement pattern, (3) increase equity, and (4) maintain debt service at or below \$20 per patient day," and that the criteria of financial feasibility and cost containment were "clearly demonstrated in both projects." The written record of your review which you forwarded to this office does not clearly document such a request to the Kettering Medical Center, nor does it support your statements that the proposals in fact met all of these criteria.

3. The application for review of the Kettering Medical Center proposal was deemed by the DPA to be incomplete and further information was requested (in the April 2, 1976, letter from Stephen F. Sears to Marlowe H. Schaffner, M.D.). Pursuant to the section 1122 regulations at 42 CFR 100.106(a)(3), when timely notification of incompleteness is provided, the review period begins on the date the additional information completing the application is received. Thus, your determination of the date on which the review period began was in error. This had the effect of shortening the period within which the areawide health planning agency could study the proposal as well as the period for your consideration of that agency's negative finding and recommendation. The DPA's hasty decision, which was contrary to the recommendation of the areawide health planning agency, is especially troublesome in light of your own Rule HE-8-18(A):

"Plans, policies, criteria and guidelines developed by the areawide agencies will be utilized by those agencies for the purpose of conducting the indepth review provided for in the DPA subcontract with each agency."

The purpose of the section 1122 program is to ensure that Federal health dollars are not spent in support of unnecessary capital expenditures, and further, to discourage health care facilities and health maintenance organizations from making capital investments for unneeded services and facilities. These purposes were endorsed by the executive branch of the Ohio State government (in the section 1122 agreement with this Department) as well as the Ohio legislature (in enacting House Bill Number 908 which authorized the performance of the regulatory functions of the National Health Planning and Resources Development Act of 1974 and the section 1122 review function). The actions taken by the Ohio Department of Health during the course of the review in question indicate that it is not contributing to the goals of the section 1122 program.

The Ohio Department of Health has been designated on a conditional basis, under Title XV of the Public Health Service Act, to be the State Health Planning and Development Agency. This Act, at section 1521(b)(2)(A), authorizes the Secretary to enter into such a conditional agreement with a Governor of a State "with a view to determining the capacity of the designated State Agency to administer the...health planning and development functions prescribed by section 1523." If the Secretary determines that the agency has this capability, then he may enter into a full designation agreement.

One of the functions required of a State Health Planning and Development Agency before it may reach full designation is the administration of a certificate of need program which prevents the offering or development of unneeded facilities and services. The experience of the State in administering the section 1122 program will certainly be a major factor in the Secretary's determination as to the capability of the Ohio Department of Health to administer a certificate of need program which meets the requirements of the law.

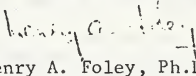
If the Secretary were to find that a State Health Planning and Development Agency did not have the capacity to administer a satisfactory certificate of need program, he would have to turn down its application for full designation (or revoke full designation after it has been granted). If a conditionally designated State Health Planning and Development Agency were to fail to qualify for full designation, then that agency could not receive Federal funds

authorized by Titles XV and XVI of the Public Health Service Act. If, moreover, there is no designation agreement in effect for a State on September 30, 1980, the Public Health Service Act, at section 1521(d), specifies that the Secretary "may not make any allotment, grant, loan, or loan guarantee, or enter into any contract" under the Public Health Service Act and two related Acts for the development, expansion, or support of health resources in the State until such an agreement is in effect. It is important to realize that a substantial amount of Federal funds, in addition to Federal support for health planning activities, are placed in jeopardy in this latter situation. In this situation, the Secretary has no discretion: he would have to deny Federal funds for the development, expansion, or support of health resources to any prospective grantee, contractor, or institution located in the State -- this restriction does not apply solely to funds intended for the State government itself.

On the other hand, in the event that an agency which has been conditionally designated is found not to be capable of assuming the functions required for full designation, the Secretary could then consider an application for designation, on a conditional basis, of a different State agency to be the State Health Planning and Development Agency. Alternatively, the Act, at section 1523(b)(1), provides that the agency administering the certificate of need and section 1122 review functions may be an agency of the State other than the State Health Planning and Development Agency.

I would appreciate your prompt response concerning these issues.

Sincerely yours,

  
Henry A. Foley, Ph.D.  
Administrator



## OHIO STATE MEDICAL ASSOCIATION

EXECUTIVE OFFICES: 600 SOUTH HIGH STREET, COLUMBUS, OHIO 43215 • TEL. 614-228-6971

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HART F. PAGE, COLUMBUS

February 2, 1978

Joseph A. Califano, Jr.  
Secretary of Health, Education, and Welfare  
200 Independence Avenue, S. W.  
Washington, D. C. 20201

Dear Mr. Secretary:

The Ohio State Medical Association must protest strongly the overt activities of the Health Resources Administration, U. S. Public Health Service.

I refer specifically to a threatening letter written by Henry A. Foley, administrator of the HRA, January 17, 1978, addressed to the Ohio Director of Health, John A. Ackerman, M.D., M.P.H.

The letter is a patent and transparent effort by Mr. Foley to insert himself and his office into differences of opinion over the needed expansion of medical facilities in an Ohio community.

It is an almost incredible fact that Mr. Foley saw fit to "leak" to the opponents of the expansion of two medical facilities his letter several days before Dr. Ackerman received the letter. To do so is gravely insulting to a dedicated public health physician, to those of us in Ohio who are striving to make health planning succeed, and to Congressman Paul Rogers, the author of the planning legislation.

Mr. Foley's insult to Dr. Ackerman is further compounded by the fact that he did not extend this respected state official the courtesy of even discussing the matter with Dr. Ackerman before writing him the threatening letter.

Mr. Secretary, the "leak" technique may be and is used in Washington with considerable frequency, but there is no place for it here in Ohio. Also, I would ask you to remind Mr. Foley that Mr. Rogers, in explaining the purpose and intent of his legislation before a national meeting of medical leaders stated:

"And we've written the planning bill. Contrary to what some may think, it doesn't put all the power in the Secretary because we wrote it where it wouldn't."

If your Mr. Foley had taken the time to discuss the issue with Dr. Ackerman, he would have easily learned that (1) present and future projections clearly demonstrate that the approved projects are necessary and in the best interests of the

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consumers they are to serve, (2) the projects were thoroughly reviewed over a considerable period by experienced local health care delivery experts, (3) the projects were approved for Medicare and Medicaid purposes by the U. S. Department of Health, Education and Welfare, (4) Dr. Ackerman gave very serious and very conscientious attention to these matters, working in constant communication and in a spirit of cooperation with the local interests (a quality your Mr. Foley appears to lack).

If health planning is to succeed, it must be carried on in a spirit of cooperation, openly and above board. It must be approached with an reasonable attitude, and it must involve all interests equally.

We here in Ohio abide by those principles. We expect the Department of Health, Education and Welfare to do the same.

Sincerely,

William M. Wells, M.D., President  
Ohio State Medical Association

WMW:ii



## RENAL PHYSICIANS ASSOCIATION

ONE IBM PLAZA—SUITE 3100

CHICAGO, ILLINOIS 60611

February 20, 1978

Paul G. Rogers, Chairman  
 Subcommittee on Health and the Environment  
 House Interstate and Foreign Commerce  
 2407 Rayburn House Office Building  
 Washington, D.C. 20515

Dear Mr. Rogers:

The Renal Physicians Association seeks the opportunity to present the following statement as a matter of record concerning the hearings and deliberations on The National Health Planning and Resources Development Act (PL-93-641).

It is our desire to comment first on the program in a general way, relative to certain basic concepts concerning the law, its goals and their impact, and then in a specific way as it relates to the Medicare ESRD Program enacted under PL-92-603.

General Considerations

The basic concept of this law was to establish local Health Systems Agencies, whose function was to contain the spiraling costs of health care through a system of coordinated planning for health care. To this end, the HSA would plan for needed services, permit orderly and progressive development of services, set standards which would either upgrade services or lead to their deletion, and prevent duplication of unnecessary services and facilities.

The very essence of the law, i.e., to halt costly duplication and unneeded services is, in itself, an example of what the Medicare ESRD Program set about to prevent - duplication of already existent planning services. Much in the way of health planning was either developed, or in the process of being developed at the State level when the law was enacted. Thus, the Federal Government not only duplicated a program already in place in many areas, but did it at great cost to the taxpayer.

Should all the HSAs ultimately receive designation, the cost to the health care system will be additional billions. We believe Congress should study the cost-benefit ratio of this multi-billion dollar program the same way they are demanding such analyses of health care providers for new services, equipment, and programs - until now that has not happened.

Secondly, the HSAs are faced with tasks that simply are not achievable through a body of volunteer and unskilled individuals who now operate them, and who have little or no knowledge about health care, health planning, cost analysis, cost-benefit ratios, and the other myriad of complex factors which are the components of the health care system.

Further, in many areas of the country, it has become evident that the HSAs have not drawn upon knowledgeable experts in specific fields before embarking

upon program activities within their HSPs, resulting in unreasonable and imprudent goals.

Thirdly, the composition of HSA Boards have become a crazyquilt. The manner of selection to the boards is variable from HSA to HSA, and in some instances, reflect local political controls and influences. A standardized system of board selection should be adopted in which all major providers of care, institutional and physician, are given a balanced voice on the board.

The exclusion of major institutional providers of care from a voice on the board and policy making decisions is hardly a fair way to implement a health care program at the local, regional, as well as national level.

There is a major fallacy in the entire concept of "consumer" representation, as a majority body on HSA Boards. Not only is health care planning placed in the hands of unskilled individuals, but, as Medicare Director Thomas Tierney recently stated at the Blue Cross-Blue Shield Health Economics Conference in January, the "...true consumer (of health care) is the prescribing physician." Yet, physician representation on the HSA Boards and various planning functions represent less than 10% of the board composition as a national survey shows.

Consequently, the majority of board members of HSAs, as presently designed, should be changed so as to reflect a proper balance for that which is necessary for effectiveness in the health care field. Simply, all major institutional providers should be given a seat on the HSA Board by mandate, along with representatives of the physician community so as to constitute a majority of board members, not a minority as exists presently.

The proposed amendment to extend certificate of need legislation to physicians' offices is not only an intrusion into the ability of an individual physician remains unlikely as a way to achieve cost savings. Historically, treatments and diagnostic procedures are far less costly in an individual practitioner's office than in an institutional setting.

Further, the proposed CON amendment is pegged at \$150,000. It would not be long before that figure would be reduced to include equipment less costly than that amount. The individual physician who wishes to practice, for example, sophisticated ophthalmology, could easily exceed these arbitrary figures and he would easily be excluded from practicing his specialty in an office setting.

The concept is wrong and the desired effect would, in the end, drive up costs because it would eliminate a now competitive side of the health care market by concentrating certain equipment and procedures in high cost settings. In addition, the expenditure for equipment purchase does not involve public funds, and should not be subject to controls directed at such funds.

The relationship of HSAs to State Health Departments will continue to be one of increasing identity struggle. The HSAs, with federal funding and the force of federal regulations, have already exerted authority in areas not properly within their realm.

The entire federal program would have been better served if funds for the

HSAs had been diverted towards strengthening State Health Agencies, given proper guidelines for planning and funding, with the resultant effect of a more efficient, better conceived, and far less costly program.

#### Medicare ESRD-HSA Considerations

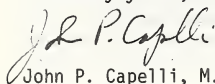
In relation to the Medicare ESRD program and the regulations governing this service, certain HSAs in this country have taken it upon themselves in certain areas of the country to extend their authority into areas not within their purview. Unfortunately, the proposed Rules for National Guidelines for Health Planning, Federal Register, September 23, 1977, and January 20, 1978, have merely adopted the ESRD Regulations published in final form on June 6, 1976. These regulations encompass many areas other than ESRD planning and utilization. Thus, without specifying those precise areas relative to HSA functions, certain HSAs have intruded into areas of medical review, requests for cost data for operating facilities with the intent to take punitive action if the facility deviated from a median cost, and application of requirements for patient care to cite a few examples.

The ESRD regulations establish ESRD Networks and a Medical Review Board, whose functions are to advise the Secretary on facility participation and Network needs. However, there has been inconsistency in the relationship between ESRD Networks and HSAs, relative to these functions. Specific statutory language should be included in any proposed amendments which delineate what areas of ESRD planning are properly HSA function, and a requirement for HSAs to draw upon the expertise existent within the ESRD Network Councils and Medical Review Boards. Clear definitions of the HSA function relative to hemodialysis and transplantation services should be handled no differently than those delineations relative to open-heart surgery, cardiac catheterization, obstetrical services, and the other services listed in the Health Planning Guidelines.

The RPA wishes to thank you, the Committee, and its staff, for the opportunity to have its views made known on this very important legislative activity.

Thank you.

Sincerely yours,



John P. Capelli, M.D.  
President, RPA

JPC/pf

## AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

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815 SIXTEENTH STREET, N.W.  
 WASHINGTON, D.C. 20006  
 (202) 637-8000

February 23, 1978

Honorable Paul G. Rogers, Chairman  
 Subcommittee on Health and the Environment  
 Committee on Interstate and Foreign Commerce  
 U.S. House of Representatives  
 Washington, D.C. 20515

Dear Mr. Chairman:

In response to Congressman Satterfield's letter to me dated February 14, 1978, requesting my comments with respect to the Administration's proposed amendments to the Health Planning and Resources Development Act (P.L. 93-641), I submit the following:

Section 203 would allow a public regional planning body or a unit of general local government to approve the budget of the separate governing body of the planning agency, the long and short range plans and remove for cause members of the governing body for health planning. This section would place planning under local government control.

Present law is very unclear to how the public Health System Agencies (HSAs) are to select the members of the separate governing body for health planning. Therefore, the law does need clarification on this point. The AFL-CIO believes both public and private governing bodies should be subject to the same requirements and, in particular, have a majority of consumers on the governing body who are representative of the socio-economic composition of the community.

Section 209 would permit HSAs to receive contributions from Blue Cross, Blue Shield and commercial health insurers. This would inevitably lead to third party domination of the planning process. The AFL-CIO strongly opposes Section 209.

Section 213 would eliminate the requirement that state certificates of need (CON) programs determine the need for the establishment of health maintenance organizations (HMOs). The AFL-CIO strongly supports this provision because HMOs are a solution to rising health care costs and not part of the problem. Facilities, including hospitals, and equipment used by HMOs should also be exempt from state CON laws. The Administration's bill does not make this clear.

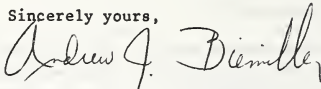
Sections 217 and 218 provide that the Governor of a state appoint the chairman of the Statewide Health Coordinating Council (SHCC) and also require the state health plan developed by SHCC be subject to approval by the Governor. These two sections would violate the intent of present law which places emphasis on citizen participation in the health planning process. This is a major structural change which will require new regulations. The AFL-CIO opposes such a major structural change at this time. The present law has not yet had a chance to work. Such a substantive change will necessarily mean a further delay in implementing comprehensive health planning. We have covered this point in our testimony on H.R. 10460.

Section 219 would require state and local planning agencies to utilize only those criteria specified by the Secretary as a basis for approving facilities, equipment or services of an HMO. The AFL-CIO, as stated above (Sec. 213), believes HMOs should be exempt from state CON requirements.

Section 301 of Title III of the bill provides grant funds to assist in liquidating the outstanding debt of a hospital that was determined to be unneeded and, therefore, subject to closure or conversion. The financial institutions are taken care of, but there is no provision to protect the employment rights of laid off employees. Such employees should receive severance pay and/or reemployment rights in other hospitals.

These comments together with our testimony on H.R. 10460 outline the views of the AFL-CIO with respect to the proposed amendments to the Health Planning and Resources Development Act of 1974.

Sincerely yours,



Andrew J. Biemiller, Director  
DEPARTMENT OF LEGISLATION

cc: Congressman David Satterfield III





1747 Pennsylvania Ave., N.W., Suite 600, Washington, D.C. 20006

February 24, 1978

The Honorable Paul G. Rogers, Chairman  
 Subcommittee on Health and the Environment  
 Committee on Interstate and Foreign Commerce  
 Room 2415, Rayburn House Office Building  
 Washington, D.C. 20515

ATTN: Bob Crane

Dear Chairman Rogers,

The American Clinical Laboratory Association has reviewed the Department of Health, Education and Welfare's proposed amendments to Public Law 93-641, the National Health Planning and Resources Development Act of 1974. ACLA's comments relate to Section 213 of the HEW bill which would require all purchasers of major medical equipment costing or valued at more than \$150,000 to obtain certificate of need. As ACLA indicated in its testimony on H.R. 10460, ACLA firmly believes that such equipment purchases made by independent laboratories should be exempt from provisions of this legislation extending certificate of need coverage. Independent laboratories are regulated by the competitive market in which they operate. This competition curtails price hikes, discourages unwarranted expansion and guards against equipment purchases more effectively and efficiently than a certificate of need program could.

General Counsel:  
 H. Robert Halper, Esq.  
 O'Connor & Hannan  
 1747 Pennsylvania Ave., N.W.  
 Washington, D.C. 20006  
 (202) 785-8700

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ACLA's written and oral statement on H.R. 10460, as well as its statement on Competition in the Independent Laboratory Market (submitted to the Subcommittee on February 23, 1978) apply with equal force to Section 213 of the Administration's bill.

If you have any questions, please do not hesitate to contact me.

Sincerely yours,

*H. Robert Halper*

H. Robert Halper

cc: The Honorable David E. Satterfield

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Blue Cross Association  
840 North Lake Shore Drive  
Chicago, Illinois 60611  
312/329-6000



National Association of Blue Shield Plans  
211 East Chicago Avenue  
Chicago, Illinois 60611  
312/943-8181

March 7, 1978

The Honorable Paul G. Rogers  
Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D. C. 20515

Dear Chairman Rogers:

This letter represents an expanded response to a question you posed during my testimony on February 1, 1978 before the Subcommittee on H.R. 10460, Health Planning and Resources Development Amendments. Specifically, you wished to know how our recommendation could be accomplished whereby all payers recognize appropriate fixed costs associated with partial closures and conversions of hospital facilities.

With respect to the Medicare program, my staff believes that no change in Title XVIII of the Social Security Act itself would be necessary to authorize recognition in the Medicare reimbursement mechanism for such costs. Rather, reimbursement allowances for such costs can be accommodated through amendment to specific sections of current regulations which govern Medicare reimbursement to hospitals. We would be pleased to work with Congressional staff on identifying the specific sections of these regulations that would need to be modified.

With respect to Medicaid Programs, where considerable variability exists among the states in specific hospital reimbursement practices, amendment in Title XIX legislation may well be necessary to insure sufficient uniformity on this matter.

Should the appropriate changes be accomplished in the key government health financing programs, we envision few obstacles to the Blue Cross organization, the other major contracting third party hospital payment mechanism, successfully accomplishing the same result on a voluntary basis in cooperation with member health care institutions. Based on the nature and extent of state governmental regulation of an individual Plan's premium rates, contracts with hospitals, and/or payments to hospitals, the need may arise in selected locales for Plans to work closely with state government to achieve the desired result; however, the weight of general public opinion in favor of such a payment program should serve to ensure the necessary degree of cooperation among the Plan, hospitals, and state regulatory bodies.

If you have any more questions, please feel free to contact our Washington office and we will provide whatever further assistance we can.

Sincerely,

Neil Hollander  
Vice President

[The following letter from Congressman Satterfield was sent to a number of organizations for their response. The text of H.R. 11077 and replies to the letter are attached.]

DAVID E. SATTERFIELD III  
30 DISTRICT, VIRGINIA

MEMBER OF:  
COMMITTEE ON INTERSTATE  
AND FOREIGN COMMERCE  
COMMITTEE ON VETERANS' AFFAIRS

WASHINGTON OFFICE:  
2348 RAYBURN OFFICE BUILDING

RICHMOND OFFICE:  
11006 FEDERAL BUILDING  
400 N. 8TH STREET 23240

**Congress of the United States**  
**House of Representatives**  
**Washington, D.C. 20515**

February 14, 1978

Dear --:

In his recent testimony before the Subcommittee on Health and the Environment, Mr. Hale Champion, Under Secretary of HEW, stated that DHEW intended to propose amendments to Public Law 93-641, the Health Planning and Resources Development Act of 1974.

Later in the hearings, I requested that the witnesses before our Subcommittee be given an opportunity to comment on these proposals prior to mark-up sessions by the Subcommittee. Chairman Rogers agreed and ordered that the hearings record remain open to receive such comments for a period of at least 10 days following receipt of the proposed amendments.

The DHEW draft bill has now been received and a copy is enclosed for your consideration. If you desire to comment please do so in writing and mail to:

Honorable Paul G. Rogers, Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D. C. 20515          ATTN: Bob Crane

Comments must be received no later than February 24th.

I would also appreciate it if you would send a copy of your comments to me.

With best wishes, I am

Sincerely yours,

DAVID E. SATTERFIELD, III

DES/JJ/al



95TH CONGRESS  
2D SESSION

# H. R. 11077

---

## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 22, 1978

Mr. STAGGERS introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

---

## A BILL

To amend title XV of the Public Health Service Act to revise and extend the authorities and requirements under that title for health planning, to provide for assistance to hospitals in discontinuing inappropriate services, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3               SHORT TITLE AND REFERENCES IN ACT

4       SECTION 1. (a) This Act may be cited as the "Health  
5       Planning Amendments and Hospital Services Discontinua-  
6       tion Act of 1978".

7       (b) Whenever in this Act an amendment or repeal is  
8       expressed in terms of an amendment to, or repeal of, a

1 section or other provision, the reference shall be considered  
 2 to be made to a section or other provision of the Public  
 3 Health Service Act, unless otherwise specifically stated.

#### 4 TITLE I—THREE-YEAR AUTHORIZATION

##### 5 EXTENSIONS

##### 6 THREE-YEAR AUTHORIZATION EXTENSIONS

7 SEC. 101. (a) Section 1516(c) (1) is amended by  
 8 striking out “and” after “1976,” and by inserting before  
 9 the period “, \$115,400,000 for the fiscal year ending Sep-  
 10 tember 30, 1979, and such sums as may be necessary for  
 11 the fiscal years ending September 30, 1980, and Septem-  
 12 ber 30, 1981”.

13 (b) Section 1525(c) is amended by striking out “and”  
 14 after “1976,” and by inserting before the period “,  
 15 \$30,000,000 for the fiscal year ending September 30, 1979,  
 16 and such sums as may be necessary for the fiscal year end-  
 17 ing September 30, 1980, and September 30, 1981”.

18 (c) Section 1526(c) is amended by striking out “and”  
 19 after “1976,” and by inserting before the period “, \$2,000,-  
 20 000 for the fiscal year ending September 30, 1979, and  
 21 such sums as may be necessary for the fiscal years ending  
 22 September 30, 1980, and September 30, 1981”.

23 (d) Section 1534(d) is amended by striking out  
 24 “and” after “1976,” and by inserting before the period “,  
 25 \$6,900,000 for the fiscal year ending September 30, 1979,

1 and such sums as may be necessary for the fiscal years  
 2 ending September 30, 1980, and September 30, 1981".

### 3 TITLE II—AMENDMENTS TO HEALTH PLANNING 4 AUTHORITIES

#### 5 HEALTH SERVICE AREAS IN METROPOLITAN AREAS

6 SEC. 201. The last sentence of section 1511 (a) is  
 7 amended by striking out "each State" and inserting in lieu  
 8 thereof "any State".

#### 9 REVISION OF BOUNDARIES OF HEALTH SERVICE AREAS

10 SEC. 202. The first sentence of section 1511 (b) (4)  
 11 is amended by inserting after "the requirements of subsec-  
 12 tion (a)" the following: "or a change in the boundary of  
 13 such area would result in a health service area which better  
 14 meets the requirements of such subsection".

#### 15 IMPROVED COORDINATION BETWEEN GOVERNING BODIES 16 FOR HEALTH PLANNING AND THEIR PUBLIC REGION- 17 AL PLANNING BODIES OR UNITS OF GENERAL LOCAL 18 GOVERNMENT

19 SEC. 203. (a) Section 1512 (b) (3) (A) is amended  
 20 by striking out the first sentence and inserting in lieu  
 21 thereof the following: "A health systems agency which is  
 22 a public regional planning body or unit of general local  
 23 government shall establish a separate governing body for  
 24 health planning in accordance with subparagraph (C),  
 25 which shall have the responsibilities prescribed by subpara-

1 graph (B), and which has exclusive authority to perform  
 2 for the agency the functions described in section 1513  
 3 except as otherwise provided in subparagraph (B) of this  
 4 paragraph. The public regional planning body or unit of  
 5 general local government may remove for cause members  
 6 of the governing body for health planning.”.

7 (b) Section 1512 (b) (3) (B) (i) is amended by in-  
 8 serting immediately before the semicolon “, but the budget  
 9 of a health systems agency described in clause (B) or (C)  
 10 of paragraph (1) of this subsection shall be subject to ap-  
 11 proval by the public regional planning body or unit of  
 12 general local government”.

13 (c) Section 1512 (b) (3) (B) (ii) is amended by in-  
 14 serting immediately before the semicolon “, but both plans  
 15 (and amendments to those plans) in the case of a health  
 16 systems agency described in clause (B) or (C) of paragraph  
 17 (1) of this subsection shall be subject to approval by the  
 18 public regional planning body or unit of general local  
 19 government”.

#### 20 CONFIDENTIALITY OF PERSONNEL RECORDS

21 SEC. 204. (a) Section 1512 (b) (3) (B) (viii) is  
 22 amended (1) by striking out “business meetings” and in-  
 23 serting in lieu thereof “business meetings (other than those

1 parts of meetings that involve personnel matters)", and  
 2 (2) by striking out "records and data" and inserting in  
 3 lieu thereof "records and data (other than records and data  
 4 on the personnel of the health systems agency)".

5 (b) Section 1522 (b) (6) is amended (1) by striking  
 6 out "business meetings" and inserting in lieu thereof "busi-  
 7 ness meetings (other than meetings on personnel matters)",  
 8 and (2) by striking out "records and data" and inserting in  
 9 lieu thereof "records and data (other than records and data  
 10 on the personnel of the State Agency)".

11 (c) Section 1524 (b) (3) is amended by striking out  
 12 "business meetings" and inserting in lieu thereof "business  
 13 meetings (other than those parts of meetings that involve  
 14 personnel matters)".

15 CONSUMER MEMBERS OF -THE GOVERNING BODY OF -A  
 16 HEALTH SYSTEMS AGENCY

17 SEC. 205. Section 1512 (h) (3) (C) (i) is amended by  
 18 striking out "who are consumers of health care and who are  
 19 not (nor within the twelve months preceding appointment  
 20 been) providers of health care" and inserting in lieu thereof  
 21 "who are not providers of health care and have not within  
 22 the twelve months preceding appointment been direct provid-  
 23 ers of health care (as defined in section 1531 (3) (A))".



1 PROVIDER MEMBERS OF THE GOVERNING BODY OF A  
2 HEALTH SYSTEMS AGENCY

3 SEC. 206. Section 1512 (b) (3) (C) (ii) is amended by  
4 striking out "who represent" and inserting in lieu thereof  
5 "shall include representatives of".

6 NONMETROPOLITAN MEMBERS OF THE GOVERNING BODY  
7 OF A HEALTH SYSTEMS AGENCY

8 SEC. 207. Section 1512 (b) (3) (C) (iii) (II) is  
9 amended by inserting "at least" before "equal".

10 OFFICIALS ON THE GOVERNING BODY OF A HEALTH  
11 SYSTEMS AGENCY

12 SEC. 208. (a) Section 1512 (b) (3) (C) (iii) (I) is  
13 amended to read as follows:

14 " (I) include representatives of public and  
15 private agencies in the health service area con-  
16 cerned with health,".

17 (b) Section 1512 (b) (3) (C) is amended (1) by re-  
18 numbering clauses (ii), (iii), and (iv) as (iii), (iv), and  
19 (v), respectively, and (2) by inserting after clause (i) the  
20 following:

21 " (ii) At least one quarter of the members shall  
22 be public elected officials and other representatives  
23 of governmental authorities in the agency's health  
24 service area."

25 (c) Section 1512 (b) (3) (C) (i) (as amended by sec-

1 tion 205 of this title) is further amended by inserting “,  
 2 who are not public elected officials or other representatives  
 3 of governmental authorities in the health service area,” after  
 4 “(as defined in section 1531 (3) (A) )”.

#### 5 CONTRIBUTIONS FROM HEALTH CARE INSURERS

6 SEC. 209. The first sentence of section 1512 (b) (5) is  
 7 amended by striking out “it is” and inserting in lieu thereof  
 8 “it is a health care insurer or it is”.

#### 9 RETURN OF HEALTH SYSTEMS AGENCY TO CONDITIONAL 10 STATUS

11 SEC. 210. Section 1515 (c) (3) is amended by adding  
 12 at the end the following: “If an agreement under this sub-  
 13 section is not renewed by the Secretary, he may enter into  
 14 an agreement under subsection (b) with the entity for a  
 15 period of conditional designation which may not exceed  
 16 twenty-four months, if the Secretary finds that the period of  
 17 conditional designation should enable the entity to qualify  
 18 again for designation under this subsection, and that the pe-  
 19 riod of conditional designation will assist in carrying out the  
 20 purposes of this title.”.

#### 21 CARRYOVER OF GRANT FUNDS

22 SEC. 211. (a) (1) The second sentence of section  
 23 1516 (a) is amended by striking out “, and shall be avail-  
 24 able for obligation” and all that follows in such sentence  
 25 and inserting in lieu thereof a period.

1       (2) Such section is amended by inserting after the  
2 second sentence the following: "Funds under a grant which  
3 remain available for obligation at the end of the fiscal  
4 year in which the grant has been made shall remain avail-  
5 able for obligation in the succeeding fiscal year, but no  
6 funds under any grant to an agency may be obligated in any  
7 period in which a designation agreement is not in effect for  
8 such agency, except that in the case of a grant made to a  
9 conditionally designated entity with which the Secretary will  
10 not enter into a designation agreement under section  
11 1515 (c), such funds shall be available for obligation for  
12 such additional period as the Secretary determines such  
13 entity will require to satisfactorily terminate its activities  
14 under the agreement for its conditional designation".

15       (b) The second sentence of section 1525 (a) is amended  
16 to read as follows: "Funds under a grant which remain  
17 available for obligation at the end of the fiscal year in which  
18 the grant has been made shall remain available for obliga-  
19 tion in the succeeding fiscal year, but no funds under any  
20 grant to a State Agency may be obligated in any period in  
21 which a designation agreement is not in effect for such  
22 State Agency.".

23       (c) Section 1526 (c) is amended (1) by striking out  
24 "(1) such a grant" and all that follows through "(2)",  
25 and (2) by adding at the end the following: "Funds under

1 a grant which remain available for obligation at the end of  
 2 the fiscal year in which the grant has been made shall  
 3 remain available for obligation in the succeeding fiscal year,  
 4 but no funds under any grant to a State Agency may be  
 5 obligated in any period in which a designation agreement  
 6 is not in effect for such State Agency.”.

7 PLANNING GRANTS TO HEALTH SYSTEMS AGENCIES

8 SEC. 212. (a) Section 1516 (b) is amended to read as  
 9 follows:

10 “(b) The amount of any grant under subsection (a)  
 11 to a health systems agency designated under subsection (b)  
 12 or (c) of section 1515 shall be determined by the Secre-  
 13 tary.”

14 (b) Section 1516 (c) is amended (1) by repealing  
 15 paragraph (2), and (2) by striking out the paragraph  
 16 designation “(1)”.

17 MAJOR MEDICAL EQUIPMENT AND HEALTH MAINTENANCE  
 18 ORGANIZATIONS UNDER A STATE CERTIFICATE  
 19 OF NEED PROGRAM

20 SEC. 213. (a) The first sentence of section 1523 (a)  
 21 (4) is amended by inserting “and new major medical  
 22 equipment” after “new institutional health services”.

23 (b) The second sentence of section 1523 (a) (4) is  
 24 amended by striking out “organizations” each place it oc-  
 25 curs and inserting in lieu thereof “equipment”.

1 (c) Section 1531 (5) is amended by striking out "and  
2 health maintenance organizations" and "and organizations".

3 (d) Section 1531 is amended by adding after clause (5)  
4 the following:

5 " (6) The term 'major medical equipment' means  
6 equipment which is used in the provision of health care  
7 and whose cost or fair market value (whichever is  
8 greater) exceeds \$150,000."

9 CONFORMITY WITH STATE PLANS UNDER A STATE

10 CERTIFICATE OF NEED PROGRAM

11 SEC. 214. The second sentence of section 1523 (a) (4)  
12 is amended by inserting "and consistent with the State  
13 health plan under this title and the State medical facilities  
14 plan under title XVI" after "found to be needed".

15 REVIEW OF NEW INSTITUTIONAL HEALTH SERVICES

16 SEC. 215. (a) Paragraph (5) of section 1523 (a) is re-  
17 pealed, and paragraph (6) is renumbered as (5).

18 (b) The second sentence of section 1521 (b) (2) (B) is  
19 amended by inserting "(i) shall require that the designated  
20 State Agency, unless the State has an agreement in force  
21 with the Secretary under section 1122 of the Social Security  
22 Act, make findings as to the need for new institutional health  
23 services proposed to be offered within the State, after con-  
24 sideration of recommendations submitted by health systems



1 agencies under section 1513 (f) respecting such services, and  
 2 (ii) " after "Secretary".

3 (c) Section 1513 (f) is amended by striking out "para-  
 4 graphs (4) and (5) of section 1523 (a)" and inserting in  
 5 lieu thereof "section 1523 (a) (4) and section 1521 (b) (2)  
 6 (B) (i),".

7 (d) Section 1522 (b) (13) is amended (1) by strik-  
 8 ing out "(5), or (6)" and inserting in lieu thereof "or  
 9 (5)", and (2) by striking out "(f), (g), or (h)" and in-  
 10 serting in lieu thereof "(g) or (h)".

11 (e) Section 1523 (c) is amended by striking out "(4),  
 12 (5), or (6)" and inserting in lieu thereof "(4) or (5)".

13 PROPORTIONAL REPRESENTATION OF HEALTH SYSTEMS  
 14 AGENCIES ON STATEWIDE HEALTH COORDINATING  
 15 COUNCILS

16 SEC. 216. (a) Section 1524 (b) (1) (A) is amended  
 17 (1) by striking out clause (ii) and by redesignating clause  
 18 (iii) as clause (ii), and (2) by amending the first sen-  
 19 tence of clause (ii) (as so redesignated) to read as follows:  
 20 "The number of representatives on the SHCC to which a  
 21 health systems agency is entitled shall be proportional to the  
 22 share of the State's population in the agency's health service  
 23 area, except that each agency shall be entitled to at least one  
 24 representative on the SHCC."

1 (b) Section 1524 (b) (1) (A) (i) is amended (1) by  
 2 striking out "at least five", and (2) by adding at the end  
 3 the following: "Each agency shall submit a number of nomi-  
 4 nees to the Governor which is at least twice the number  
 5 of representatives on the SHCC to which the agency is  
 6 entitled."

7 SELECTION BY GOVERNOR OF CHAIRMAN OF THE STATE-  
 8 WIDE HEALTH COORDINATING COUNCIL

9 SEC. 217. Section 1524 (b) (2) is amended to read as  
 10 follows:

11 "(2) The Governor of the State shall select from  
 12 among the members of the SHCC a chairman."

13 APPROVAL OF STATE HEALTH PLAN BY GOVERNOR

14 SEC. 218. (a) Section 1524 (c) (2) is amended by add-  
 15 ing at the end the following:

16 "(C) The State health plan shall be subject to  
 17 approval by the Governor of the State. If the Governor  
 18 does not approve the plan, a revised plan submitted by  
 19 the SHCC to the Governor shall not be subject to the  
 20 requirements of subparagraph (B)."

21 (b) The heading to section 1524 is amended by adding  
 22 at the end "AND APPROVAL OF STATE HEALTH PLAN BY  
 23 GOVERNOR".

REVIEW OF FACILITIES, EQUIPMENT, AND SERVICES OF  
HEALTH MAINTENANCE ORGANIZATIONS

SEC. 219. (a) Section 1532 (c) is amended—

(1) in the material preceding paragraph (1), by striking out “Criteria” and inserting in lieu thereof “Except as provided in subsection (d), criteria”,

(2) by striking out paragraph (8),

(3) by renumbering paragraph (9) as (8), and

(4) by striking out the last sentence.

(b) Section 1532 is amended by adding at the end the following:

“(d) Criteria required by subsection (a) for health systems agency and State agency review, in relation to the facilities, equipment, or services of health maintenance organizations (as defined in section 1301), shall include only those criteria specified by the Secretary, and shall be consistent with the standards and procedures established by the Secretary under section 1306(c).”

TECHNICAL AMENDMENTS

SEC. 220. (a) Title IX and subsections (a) and (b) of section 314 are repealed.

(b) Section 1512 (b) (3) (B) (iv) is amended by striking out the comma after “(h)”.

1 (c) Section 1512 (b) (3) (B) (vi) is amended by strik-  
2 ing out "reimburse" and by inserting in lieu thereof "reim-  
3 burse (or when appropriate make advances to)".

4 (d) Section 1513 (e) (1) (A) (i) is amended (1) by  
5 inserting a comma after "Community Mental Health Centers  
6 Act", and (2) by striking out the second comma after  
7 "Drug Abuse Office and Treatment Act".

8 (e) Section 1513 (e) (1) (A) (i) is amended by strik-  
9 ing out "sections 409 and 410" and inserting in lieu thereof  
10 "section 410".

11 (f) Section 1513 (e) (1) (A) (i) is amended by insert-  
12 ing "of 1972" after "Drug Abuse Office and Treatment Act".

13 (g) Section 1513 (e) (1) (B) is amended by striking  
14 out "under titles IV, VII, or VIII of this Act" and inserting  
15 in lieu thereof "for research or training".

16 (h) Section 1514 is amended by striking out "304"  
17 and inserting in lieu thereof "305".

18 (i) The last sentence of section 1532 (a) of the Public  
19 Health Service Act is amended by striking out "States" and  
20 inserting instead "State".

21 (j) Section 1604 (b) (1) (I) of the Public Health  
22 Service Act is amended by inserting "medical" after "out-  
23 patient".

24 (k) The first sentence of section 1620 (b) (2) is  
25 amended by striking out the comma after "pay".

## EFFECTIVE DATES

SEC. 221. (a) Sections 203, 214, 216, 218, and 219 of this title, and section 213 of this title with respect to major medical equipment, are effective one hundred and eighty days after the date of its enactment.

(b) Section 212 of this title is effective October 1, 1979.

(c) The remainder of this title is effective on the date of its enactment, except that section 208 of this title shall not require the removal of any person from the governing body or executive committee of a health service agency if that person is a member of the body or committee on the date of enactment of this title.

### TITLE III—ASSISTANCE TO HOSPITALS FOR DIS- CONTINUING INAPPROPRIATE INPATIENT SERVICES

#### GRANTS TO HOSPITALS TO ASSIST IN DISCONTINUING INPATIENT HOSPITAL SERVICES

SEC. 301. (a) The Secretary may make grants to public or private nonprofit hospitals that have been in operation for at least seven years to assist them in discontinuing inappropriate inpatient hospital services.

(b) An application of a hospital for a grant under this section shall be in such form, submitted to the Secretary in such manner, and contain such information and assurances, as the Secretary may prescribe.



1 (c) Upon request by a hospital, the State health plan-  
2 ning and development agency designated under section 1521  
3 for the State in which the hospital is located shall, after re-  
4 questing the recommendations of the appropriate health  
5 systems agency designated under section 1515, make a find-  
6 ing as to the appropriations of inpatient hospital services  
7 which the hospital wishes to discontinue. The finding of a  
8 State health planning and development agency under this  
9 subsection shall not be subject to further review. The Secre-  
10 tary may not make a grant under this section to assist in  
11 discontinuing hospital services unless the State health plan-  
12 ning and development agency has made a finding that the  
13 services are inappropriate.

14 (d) The Secretary may make a grant under this section  
15 only if he determines—

16 (1) that the average per capita inpatient hospital  
17 costs in the health service area (established under section  
18 1511) in which the hospital is located will be less, if the  
19 grant is made, than if it is not made,

20 (2) that the hospital would not be able to discon-  
21 tinue the services with respect to which the application  
22 is submitted without the grant, and

23 (3) that the hospital will comply with such addi-  
24 tional conditions as the Secretary determines are  
25 appropriate.

1 (e) The amount of any grant under this section shall be  
 2 determined by the Secretary. A grant under this section may  
 3 include amounts—

4 (1) in the case of the closure of the entire hospital,  
 5 to liquidate the net outstanding debt of the hospital,

6 (2) in the case of the conversion of part of the  
 7 hospital from use for inpatient care to another health  
 8 care use, to pay for the costs of that conversion, includ-  
 9 ing costs of construction, and

10 (3) that the Secretary determines are otherwise  
 11 needed to assist in discontinuing inappropriate inpatient  
 12 hospital services.

13 (f) The Secretary may make payments under this sec-  
 14 tion in advance or by way of reimbursement, and at such  
 15 intervals and on such conditions as he finds necessary.

16 (g) Each hospital which receives a grant under this  
 17 section shall (1) establish and maintain such records, and  
 18 arrange to have performed such audits, as the Secretary may  
 19 require, and (2) make available those records to the Secre-  
 20 tary and the Comptroller General of the United States for  
 21 examination, copying, and mechanical reproduction.

#### 22 TECHNICAL ASSISTANCE

23 SEC. 302. The Secretary may provide technical assist-  
 24 ance to hospitals eligible for grants under section 301 to

- 1 assist them in discontinuing inappropriate inpatient hospital
- 2 services.

3                    APPROPRIATION AUTHORIZATIONS

- 4        SEC. 303. For the purposes of making grants and pro-
- 5 viding technical assistance under this title, there are author-
- 6 ized to be appropriated such sums as may be necessary for
- 7 fiscal years 1980 and 1981.

ARLAN STANGELAND  
7TH DISTRICT, MINNESOTA

COMMITTEES:  
GOVERNMENT OPERATIONS  
PUBLIC WORKS AND  
TRANSPORTATION

**Congress of the United States**  
**House of Representatives**  
**Washington, D.C. 20515**

February 24, 1978

OFFICES:  
1818 LONGWORTH HOUSE OFFICE BUILDING  
WASHINGTON, D.C. 20515  
(202) 225-2163

M-F BUILDING  
403 CENTER AVENUE  
MOONHEAD, MINNESOTA 56560  
(218) 233-0631

The Honorable Paul G. Rogers  
Chairman  
Subcommittee on Health and the Environment  
House Committee on Interstate and Foreign Commerce

Attention: Bob Crane

Dear Mr. Chairman:

I appreciate the opportunity to comment on the proposed amendments to P.L. 93-641, submitted by the Department of HEW.

In line with my testimony, I would suggest the following change to P.L. 93-641. Section 1513-b-2-C, Health Systems Agencies Functions reads, "shall take into account and is consistent with the national guidelines for health planning." The words "and is consistent with" should be stricken. This would assure that local H. S. A.'s would be able to provide input from the bottom upward rather than responding to national guidelines.

I would recommend that a Section be added, as C-5, which should read: "The Agency shall submit to the state Agency a detailed statement of the reasons for any inconsistencies between its HSP or AIP plan, and the national guidelines and priorities establish under this Act."

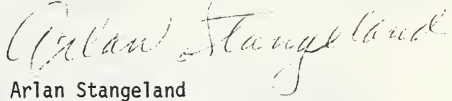
In addition, I would like to bring to your attention a concern of one of the hospital administrators in my District. He has stated to me that some type of agreement has been made between the HEW and the H. S. A.'s regarding a financial mechanism by which HEW would pay a hospital the costs incurred in closing it down, and that local H. S. A.'s would receive a percentage of that money. He indicated to me that this seemed to provide an unusual incentive to close hospitals, especially those financially weak hospitals, in many rural areas.

One point that has been brought to my attention is the fact that health planning has given little attention to medically underserved areas.

As you may know, the emphasis has been on eliminating excess hospital capability, and I would like to assure that adequate emphasis is on assuring that rural areas which suffer from lack of medical personnel are given equal attention.

With best regards, I am

Sincerely,

A handwritten signature in cursive script that reads "Arlan Stangeland". The signature is written in dark ink and is positioned above the printed name.

Arlan Stangeland  
Member of Congress





WYOMING  
EXECUTIVE DEPARTMENT  
CHEYENNE

ED HERSCHLER  
GOVERNOR

February 23, 1978

Honorable Paul G. Rogers, Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D.C. 20515

Dear Mr. Rogers:

Thank you for allowing me to comment on the proposed amendments to Public Law 93-641, the Health Planning and Resources Development Act of 1974.

The amendments offered by the Department of Health, Education, and Welfare provide for some general improvement in the Act. One minor point of duplication in the review processes would be eliminated. Also, state elected officials would have a greater opportunity to influence state health policy under these revisions.

However, they fail to address the situation of the single statewide health systems agency structure. As I indicated in my testimony, I believe that this type of system is inappropriate and inherently contains problems which are not conducive to effective and efficient health planning. I hope that you will give consideration to this matter in your deliberations.

Yours sincerely,

EH/soc



HEALTH PLANNING COUNCIL OF THE EASTERN SHORE  
P.O. BOX 776, CAMBRIDGE, MD. 21613 301/228-8911

February 17, 1978

Honorable Paul G. Rogers, Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D. C. 20515

ATTN: Bob Crane  
Re: P. L. 93-641

Dear Congressman Rogers:

We have recently received a letter from Congressman Satterfield indicating that the record of your Committee Hearings on P. L. 93-641 would remain open for 10 days following the presentation of the Administration Bill. We thank you for this additional opportunity for input and comment on revisions to P.L. 93-641 as proposed by the Administration.

For the most part we are of the opinion that the Administration's Proposal is sound, and in particular we are pleased with the changes embodied in sections 204 and 207.

There are a number of other areas where we feel that changes to the Administration's Proposal are needed. I have summarized those by section below.

Section 208: Since representatives of governmental authorities have a great many other time consuming responsibilities we have found that they frequently have difficulty attending meetings. For this reason we do not favor the change. If the change increasing that representation remains in the Bill we recommend that the quorum requirements for meetings be lowered from one half of the members to one third of the members in section 1512 of the current law.

Section 212: As our testimony on allocation of grants indicated, we favor the use of minimum funding levels for small population HSAs, with a substantial increase in the minimum funding level. In addition, we favor the recognition of local funds raised by all HSA's on an equal basis in allocating federal matching funds.

TALBOT WICOMICO WORCESTER

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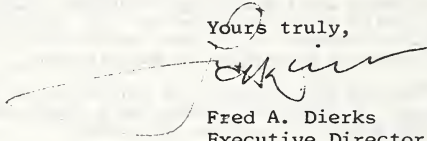
We feel that House Bill 10460, Section 206, amending section 1516 accomplishes the desired end concerning local match, and congratulate the committee for its work in this area.

Section 216: SHCC representation based on HSA population will bias State level planning decisions to metropolitan areas and high cost tertiary care, to the detriment of rural area needs for less expensive primary care. This change is highly undesirable in our view.

Section 218: State Health Plan approval by the Governor would make the SHCC an organization without meaningful function in our view, and that change is undesirable.

Again we thank you for this additional opportunity to comment on these important legislative matters.

Yours truly,



Fred A. Dierks  
Executive Director

for

Col. Bertram Parr  
Vice President  
Health Planning Council of  
The Eastern Shore

FAD:jf

19 WEST SOUTH TEMPLE  
SALT LAKE CITY, UTAH 84101  
PHONE (801) 581-3476

February 21, 1978

Honorable Paul G. Rogers, Chairman  
Subcommittee on Health & the Environment  
Committee on Interstate & Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D.C. 20515

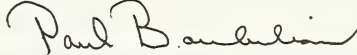
ATTENTION: Bob Crane

Dear Representative Rogers:

Attached are the comments of the members of the National Association of Single State Agencies on HR 10460, Health Planning and Resources Amendments of 1978. Included, at the suggestion of Representative David E. Satterfield, III, are several comments on the DHEW proposed amendments to PL 93-641 as submitted by Mr. Hale Champion, Under Secretary of HEW.

We hope that our comments will be helpful in the decisions your committee will be making in the next few weeks. We greatly appreciate the opportunity to express our thoughts.

Sincerely,



Paul J. Boumbulian, Secretary  
National Association of  
Single State Agencies

PJB:dg

cc: Rep. David E. Satterfield, III



Utah Health Systems Agency

COMMENTS ON  
H.R. 10460, HEALTH PLANNING AND RESOURCES  
AMENDMENTS OF 1978  
and  
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
PROPOSED AMENDMENTS TO P.L. 93-641  
  
ON BEHALF OF THE  
NATIONAL ASSOCIATION OF SINGLE STATE AGENCIES

BY: Paul J. Boumbulian, Secretary  
Executive Director  
Utah Health Systems Agency

FOR:  
The Subcommittee on Health and the Environment  
of the  
Committee on Interstate and Foreign Commerce

Paul G. Rogers, Chairman



HR 10460 Proposed Amendments

The National Association of Single State Agencies is composed of representatives of the Health Systems Agencies, State Health Planning and Development Agencies and Statewide Health Coordinating Councils of the 11 single state health service areas.

The members of the Association have analyzed HR 10460 in depth and are pleased at the overall tenor of the proposed amendments to PL 93-641; they indicate a sensitivity to the realities of implementing the act faced by the various responsible bodies.

There are several sections upon which we would like to make more specific comments. We feel that Section 204 as it refers to Section 1515 (c)(5) dilutes the concept of participatory democracy upon which the statute is predicated. It would impose a layer of bureaucratic decision-making over the health service areas of a state. The Statewide Health Coordinating Council should be maintained in its present role of overseeing both the Health Systems Agencies and the State Health Planning and Development Agencies as provided in the initial issuance of the act.

Section 205 has the potential of strengthening HSA actions and furthering the implementation of Section 1515(c)(3) even though it might appear to be a punitive provision. There are some HSA's that are hampered in accomplishing their mandated tasks due to the intransigence and organized attacks of provider groups which intimidate these HSA's and prevent

them from making the hard decisions required by law. The federal authority to limit functions or budgets of HSA's could serve as a catalyst for such HSA's to take unpopular actions and provide them with the necessary support and authority to move forward in the face of adversarial resistance.

We endorse and support Section 206, amending Section 1516 of the Act to raise the minimum level of funding for HSA's. We are especially gratified at the provision making matching non-Federal funds possible for minimally funded agencies. Section 206(b) of the amendment recognizes that there are substantial differences in the cost of implementing the Act in various settings. The reality is that there is little connection between the number of people in the area and the cost of planning.

The Association applauds Section 208 which amends Sections 1512(b)(5) and 1516(b)(2)(B)(i). Health care insurers should be encouraged to contribute funds to HSA's to better enable them to carry out their functions under the law. In many instances their level of funding is too low to perform adequately all of the mandated functions and since health care insurers have a major interest in restraining the rising cost of medical care, they should assume some of the financial burden in assisting HSA's to work toward cost containment.

In Section 210 we recommend that the second sentence of the proposed new subparagraph (D) of Section 1512(b)(3) be deleted. The other proposed provisions are intended to assure an open, well-publicized and participatory process for

selection of members of the governing bodies and we fully support these proposed amendments. However, the second sentence would be in conflict with some State laws controlling the formation and operation of non-profit corporations. The powers given to corporate boards by these laws include the power to elect their own directors. We would also be concerned that any proposed selection process for governing body members be careful to avoid any conflict with Section 1512(b)(1)(A) which prohibits control of the corporation by any other entity.

We strongly support the provisions of Section 213(a) as a major thrust in maximizing community involvement in the health planning process. We believe that such assistance should be extended to include Subarea Advisory Councils and that the Secretary should assure proper levels of funding to HSA's to insure support for this important participatory process with the understanding that additional funding will be necessary for most HSA's to comply.

Section 215 is heartily supported by the Association. It should be thoroughly understood, however, that additional funding will be necessary for most agencies to comply.

Section 216(c) is especially relevant to single state HSA's. In order to facilitate statewide planning in these states, we make the following recommendations:

1. Add a new subparagraph (C) to Section 1523(a)(1) to read "...and (C), in states with single Health Systems Agencies to jointly determine the statewide needs." The Statewide Health

Coordinating Council will make the final decision if an HSA and a SHPDA are in disagreement.

2. Amend the proposed subparagraph (D) of Section 1513(b)(2) by adding "except in states with a single health systems agency where such statewide needs will be jointly determined."
3. Amend the proposed amendment by adding the same language to Section 1524(c)(2) as suggested for Section 1513(b)(2) and continue with "and in such states the Statewide Health Coordinating Council will, after consultation with the Health Systems Agency and the State Health Planning and Development Agency, insure that the Health Systems Plan and the State Health Plan are developed in a way which is responsive to those statewide needs."

We endorse the provisions of Section 219(a) and (b) and applaud the recognition of the need to limit and specify the scope of appropriateness reviews in the light of limitations of both HSA and SHPDA resources.

We strongly urge that Congress maintain the authorizations proposed in Section 225(e) and we further urge Congress to appropriate funds consistent with the authorization. All previous elements of the statute provide mechanisms for structuring the health care system and the tools for

cost containment. However, Health Systems Agencies must have area health service development funds to deal with the accessibility, quality, continuity, availability and acceptability aspects of the health care system and to maintain operational credibility within the community. In addition, the availability of these funds will be the visible "reward" to the communities for cooperating with and supporting what many conceive to be a new expansion of governmental intervention. Without such funds many communities will tend to perceive plan implementation for balanced health services as a negative, if not downright punitive, use of governmental authority.

The Association would also like to address an item that was not covered in the proposed amendments but which experience has proved desirable to include. We recommend that a paragraph be added to Section 1532 to read, "1532(d) No determination of a State Agency under Section 1523 may be inconsistent with the State Health Plan and no recommendation of a Health Systems Agency shall be inconsistent with the applicable Health Systems Plan".



D.H.E.W. Proposed Amendments

The National Association of Single State Agencies did not receive the DHEW Proposed Amendments in time for an in-depth analysis. However, several of the proposals were discussed that coincided with or overlapped those of H.R. 10460. The following comments address only the DHEW Sections that we feel should be modified.

Section 208(b). The members of the group prefer HR 10460 Section 209(b)(1), as the DHEW proposed requirement that at least one-quarter of the HSA governing bodies be composed of public elected officials imposes yet another quota that governing bodies must meet. We do strongly agree that the inclusion of public elected officials on these bodies should be emphasized.

Section 212. We recommend that the broader amendment proposed in HR 10460 Section 206(a) and (b) be retained as the DHEW proposal gives too much discretion to the Secretary in the awarding of planning grant amounts. Also, it is exceedingly difficult to plan without some foreknowledge of potential minimum allocations.

Section 214. While this section is adequate as far as it goes, it is felt that the addition of a new section, 1527, to part C of Title XV, as proposed in HR 10460 Section 218, provides needed clarification and specificity to Certificate of Need legislation.

Section 216. This section is the same as HR 10460 Section 223 with the exception of the minimum HSA representation on the SHCC. The Association strongly recommends that the minimum representation from each HSA be set at two as proposed in the House bill.

Section 218. We vigorously oppose this section because requiring the Governor to approve the State Health Plan developed by the SHCC would give him veto power over the Plan, which was never intended in the law. We recommend that the language be changed to require consultation with the Governor rather than approval, to ensure that the citizen-volunteer process of health planning be maintained rather than allow it to become another governmental planning process.

Lest our comments, suggestions, recommendations and in places, oppositions imply an air of negativism, I would like to reiterate our concurrence with the majority of both the HR 10460 and DHEW proposals. We who are committed to carrying out the legislation, both as citizen-volunteers and staff, recognize the thought and effort that have been expended in the proposed amendments to PL 93-641. We are particularly anxious to preserve the idea of participatory democracy in health planning by the utilization of the governing bodies and the Statewide Health Coordinating Councils as the decision makers and the avoidance of health planning becoming solely a function of the bureaucracies of state or federal government.



Louis E. Gibson, M.D.  
Chairman  
Texas Statewide Health  
Coordinating Council

February 21, 1978

Honorable Paul G. Rogers  
Chairman  
Subcommittee on Health and the  
Environment  
Committee on Interstate and Foreign  
Commerce  
Room 2415, Rayburn House Building  
Washington, D.C. 20515

Att: Bob Crane

Dear Congressman Rogers:

I have reviewed the proposed amendments to Public Law #93641 as submitted by the UnderSecretary of HEW, Mr. Hale Champion. I will review these title by title and section by section.

Title I

Section 101. I believe the UnderSecretary has exercised excellent judgment in requesting funding for the years 1979, 1980 and 1981. The turmoil many agencies have been through in their organizational period should be nearing an end. Most HSA's and state agencies have not yet finished their health systems plan or accumulated an adequate data base to make an impact on the health care delivery system. I do not believe judgment on the efficacy of this Act can be rendered in less time than required by the Secretary.

Title II

Section 201. No comment.

Section 202. No comment.

Section 203. I think it would be an error to expand the authority of a public regional planning body or unit of local government that serves as an HSA in relation to the authority of the separate governing body for health planning. At times it will become necessary for the health planning body to make objective decisions with which the parent body would not agree. Giving the parent body more power and authority to remove members for cause could result in coercion of the agency. The

health planning body should have a provision in its By-Laws for it to remove members for cause.

Section 204. No comment.

Section 205. The UnderSecretary certainly is justified in this request.

Section 206. Using the phraseology suggested by the Secretary would remove some confusion on this section that currently exists.

Section 207. The UnderSecretary's phraseology would more closely carry out the intent of the Act by assuring more appropriate representation for non-metropolitan residents in the health service area.

Section 208. I agree that a large section of the board should be representative of governmental authorities. Since some boards comprise as few as thirty members and others close to 100 members, a flexible range of 10-25% might well be more appropriate. They should however be counted as consumer members, or at least put in a separate category, not affecting the consumer-provider ratio.

Section 209. No comment.

Section 210. This section would give the Secretary flexibility in dealing with HSA's that were not performing to the standards set by the department without actually decertifying the HSA. It is a very appropriate section.

Section 211. This section is quite appropriate, and could put on balance plans that need to extend over more than one year period of time.

Section 212. I feel the current allocation of grants to HSA's on a formula basis is working satisfactorily from the HSA standpoint and would like to see it continued.

Section 213. It appears that Section 213 as suggested by the Secretary is probably made to apply to such major pieces of equipment as CAT scanners. I think it would be inappropriate to place equipment under certificate of need in which the cost was under \$150,000 when not located in a medical institution, or CAT scanners regardless of location might be made subject to review. This would permit large expenditure control without other involvement in private physicians' offices. Since health maintenance organizations are unique in that they receive very extensive federal subsidy and grants and loan guarantees, they should remain under the same standards as any other agency that receives a federal categorical grant.

Section 214. No comment.

Section 215. No comment.

Section 216. Although I can appreciate the Secretary's reasoning on providing representation of HSA's on SHCC's based on

population in each HSA area rather than on the current basis of equal representation from each HSA, I also recognize that many HSA's in the Southwest, and especially in Texas, might cover large areas with a relatively low population base and with equal representation, have presented no problems on the SHCC bodies. I think this representation should be maintained.

Section 217. No comment.

Section 218. I feel this section is appropriate since implementations of state health plans will require political adjustments and the use of state funds if they are to become effective.

Section 219. As in the previous section, since health maintenance organizations are unique in that they do receive federal grants and loan guarantees, and since the local health systems agency and state agency are responsible for the designing and implementation of a health systems plan meeting the unique needs of the area, they should be able to develop their own criteria for HMO review.

Section 220. No comment.

Section 221. No comment.

### Title III.

I think the Secretary has shown excellent judgment in the introduction of Title III to this Act. I do not see how we could hope to negotiate the closure of an unneeded facility or the decrease of a service or the converting of a hospital from its use for inpatient care to other health uses without taking care of its longterm debt, and without a mechanism to prevent an excessive cost to the individuals utilizing other services in the institution. I approve of Section 301, Section 302, and Section 303.

I commend the Secretary for requesting no amendments to the section involving board composition and assume that the Secretary is prepared to track the law as rendered by the Fifth Circuit Court of Appeals in the Texas Area 5 HSA versus ACORN, case.

I also would commend the Secretary for not introducing an amendment which would change the process of nomination for board membership. In order to assure the proper mix as specified by the Act, and in order to assure that qualified individuals with understanding of the health care delivery system, special expertise, and ability, in both the provider and consumer section, the board should be allowed all possible flexibility in matters concerning future board membership. No other body could so well understand

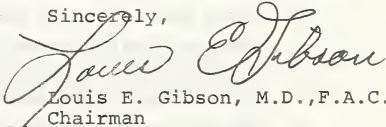


the unique problems health systems agencies face in making their determinations, as does the board of that health systems agency. Development of continuity of qualified members should be considered an asset to the implementation of the Act.

Mr. Ray Hurst, representing the Texas Hospital Association, who testified before this Committee at the same time I did, Dr. L. S. Thompson, representing the Texas Medical Association, and Dr. Louis Gibson, representing Governor Dolph Briscoe, Governor of Texas, Texas Area 5 HSA, and the Statewide Healthwide Health Coordinating Council, had a conference with Dr. Henry Foley and Mr. Daniel Zwick of DHEW Friday, February 17, regarding the provisional national guidelines. I wish to congratulate the Department for making this second set of guidelines provisional, and express my personal appreciation for this second consultation. Although we have requested this Subcommittee to remove the word "quantitative" from the Act as it refers to the issuance of national guidelines and feel that the guidelines can be best developed at the local level, Dr. Foley has maintained extreme credibility in his sincere attempt to see that workable adjustments are satisfactorily made. I enclose a memorandum of understanding, developed by the Texas delegation following the February 17th conference. This memorandum has not yet been reviewed by Dr. Foley, but will be forwarded to him in order to assure that we properly interpreted his explanations of the ramification of the guidelines.

I appreciate this additional opportunity for comment, and can assure you that the health systems agencies, the SHCC, the State Health Planning and Development Agencies, the Governor of Texas, and other bodies will make every attempt to successfully implement the current Act as any revisions which your Committee and the Congress might make, as they apply to the State of Texas.

Sincerely,

  
Louis E. Gibson, M.D., F.A.C.S.  
Chairman

LEG:ph

cc: Hon. David E. Satterfield III  
Mr. Hale Champion  
Dr. Henry Foley  
Governor Dolph Briscoe

MEMORANDUM OF UNDERSTANDING  
PERTAINING TO THE MEETING HELD IN WASHINGTON, D.C. FEBRUARY 17, 1978  
ATTENDED BY THE FOLLOWING:

1. Henry A. Foley, Ph.D.--Administrator, Health Resources Administration
2. Daniel Zwick--Deputy Administrator, Health Resources Administration
3. L.S. Thompson, Jr., M.D.--Past President, Texas Medical Association, Dallas
4. Louis E. Gibson, M.D.--Chairman, Health Systems Agency 5 and Chairman, Statewide Health Coordinating Council, Corsicana
5. Harry McAdams--Director, Office of State-Federal Relations, The State of Texas, Washington
6. Peggy Boice--Office of State-Federal Relations, The State of Texas, Washington
7. O. Ray Hurst, CAE--President, Texas Hospital Association, Austin
8. C. Dean Davis--Legal Counsel, Texas Hospital Association, Austin
9. Sam A. Edwards, Ph.D.--Vice President, Texas Hospital Association, Austin
10. Bill Newbold--Government Relations, Texas Hospital Association, Washington

The following understandings were reached:

1. Agreement was reached between all parties that the January 12, 1978 meeting attended by Ms. Peggy Boice was misinterpreted by HEW as consultation due to a lack of understanding by HEW of the role of the Office of State-Federal Relations, The State of Texas.
2. At what level will decision-making capability for exceptions to guidelines rest? This was identified as:
  - a. Individual Health Systems Agencies
  - b. Statewide Health Coordinating Council--Statewide Health Planning and Development Agency Relationships
  - c. HEW would relinquish authority to deny specific institutional exceptions. HEW's authority rests in consideration of redesignation of an agency which overtly abuses guidelines. This review authority can affect future HSA designations and funding.
3. Attention was called to all present that in Texas, exceptions to the guidelines would far exceed nonexceptions. This seemed to present no problem to Dr. Foley and Mr. Zwick as long as exceptions were well documented in the Health Services plans and State Health plans. In documenting exceptions, accessibility of care as well as costs is to be considered.

4. The inconsistencies of the two separate proposed guidelines as they pertain to titles XV and XVI of the PHS Act were addressed. Specific attention was called to the requirement for the reduced number of allowed patient days per 1,000 population. Specific assurance was given by Dr. Foley and Mr. Zwick that the guidelines pertaining to these two titles would be made consistent.
5. HEW does not have authority under current legislation to close hospital facilities, reduce services or defer payment for nonconformity by a specific institution to national guidelines except capital recovery under 1122.
6. The effect of factors at a national level producing escalating costs in the private sector was discussed. Such factors include:
  - a. The number of federal regulations to which hospitals must conform.
  - b. Effect of minimum wage on hospital costs.
  - c. Effect of increased Social Security benefits on hospital costs.
  - d. Policy of federal reimbursers to reimburse institutions at less than actual costs which causes the private sector to pick up the difference.
  - e. Policy of third party reimbursers to encourage excess hospitalization by failure to reimburse for ambulatory care.

It was recognized that these factors could not be significantly influenced at the local level.
7. The importance of providing incentives for increased ambulatory care management was pointed out.
8. This consultation on the national guidelines which this session provided prior to the termination time specified in The Federal Register was appreciated.

Louis E. Gibson, M.D. Louis E. Gibson MD

L.S. Thompson, Jr., M.D. L.S. Thompson Jr

O. Ray Hurst, CAE O. Ray Hurst

Harry McAdams Harry McAdams

SAE/1b/2/21/78

## THE MEDICAL SOCIETY OF VIRGINIA

4205 DOVER ROAD • RICHMOND, VIRGINIA 23221 • PHONE 804/353-2721



February 22, 1978

Honorable Paul G. Rogers, Chairman  
 Subcommittee on Public Health and Environment  
 Committee on Interstate and Foreign Commerce  
 Room 2415, Rayburn House Office Building  
 Washington, D.C. 20515

Dear Mr. Rogers:

The Medical Society of Virginia would like to express its appreciation to you and other members of the Subcommittee for this opportunity to comment on the proposed DHEW "Health Planning and Hospital Discontinuation Act of 1978". As I indicated to the Subcommittee on February 1, 1978, the doctors of Virginia essentially support the concept and intent of PL 93-641. However, we have many serious reservations regarding the manner in which it is being implemented in Virginia, particularly in regard to the organization and operation of the HSA's.

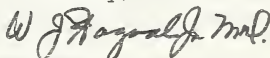
Many of our concerns and recommendations were detailed in the technical review of HR 10460 and PL 93-641 submitted to the Subcommittee on February 1. Although some of these are repeated in the following material, the proposed DHEW amendments have also been found to be much narrower in scope and content. They do not encompass as broad a range of issues as that found in previously published proposals. Therefore, we feel that the more limited nature of the DHEW amendments necessitates a restatement of our position and recommendations.

Specifically, we urge further clarification of the legislative citations and adoption procedures to be used in developing National Guidelines and National Priorities. They should mandate provider involvement. Similarly, we urge further clarification and expansion of SHCC and HSA selection, membership and procedures. In addition, the Society urges additional provisions for public hearings which give adequate notice of all HSA, SHCC, and SHPDA meetings and specification of adequate availability and access

to various health plans and applications as well as an expanded role for Subarea Advisory Councils. We are also vitally concerned with clarification and limitation of the Secretary of HEW's authority in health care matters and firmly believe that many of the decisions to be made must come at the state and local level. We also repeat our serious reservations regarding any further and totally premature expansion of HSA, SHCC and SHPDA authority particularly in decertification.

Again, we thank you for this unusual opportunity and request that you give full consideration to the following review. Please do not hesitate to contact us if we can be of any help. We are prepared to provide you with specific illustrations of the problems encountered with the Health Planning Act in Virginia.

Sincerely,

A handwritten signature in dark ink, appearing to read "W J Hagood, Jr.", written in a cursive style.

William J. Hagood, Jr., M.D.  
President

cc: Members of the Subcommittee on Public Health and Environment  
Virginia Congressional Delegation  
Governor John Dalton



Sec. 204 Confidentiality of Personnel Records

The Medical Society of Virginia is acutely aware of the need to safeguard certain data. In fact, our reviews of Virginia health systems and annual implementation plans have repeatedly emphasized the need to maintain patient record confidentiality. We have criticized the inappropriateness of proposed HSA actions involving the collection, review, and assessment of primary medical data from patient records. Thus, it may seem contradictory for the Society to take exception to this proposed section. However, our concern does not lie with the fundamental concept of confidentiality, but the lack of clarity in the proposed section.

It is unclear whether the term "personnel of the health systems agency" will extend to both HSA staff and volunteers. It could be assumed that governing board, governing body, and committee members are included as part of HSA personnel. Such clarification should be provided in the proposed section. If it is the intent to exclude HSA volunteers from the proposed section, then the term "employees or staff" should be inserted in lieu of "personnel."

Admittedly, biographical information such as the marital status or HSA income level of staff should remain confidential. However, information pertaining to the credentials of staff - education, work experience - should be a matter of public record. Such information should be provided on request since P.L. 93-641

recognizes the importance of well qualified HSA staff. Specifically, the type of staff which should be included in the HSA is cited in P.L. 93-641.

However, biographical data of HSA "volunteers" which should be disclosed by the HSA is that related to income, residence, age, and occupation. Such disclosure is necessary to determine the conformity of governing body and committee composition to P.L. 93-641 provisions. Thus, the proposed section should further specify the exact scope and type of personnel records and data which will remain confidential.

All HSA meetings should be open to the public. This is a basic tenet of P.L. 93-641. This concept should extend to all business meetings including those that involve personnel matters. The importance of staff input into the HSA decision-making process is well documented. In fact, some HSA members as well as some federally funded studies on "staff - board relationships" have been critical of staff manipulation of health planning agency boards. Thus, the HSA as a federally funded agency has an obligation to conduct its staff deliberations in public.

Sec. 206 Provider Members of the Governing Body of a  
Health Systems Agency

The change proposed in this section would further promote inadequate representation of medical providers on the HSA governing body. As indicated in an earlier review of proposed amendments, there are only a handful of practicing physicians among the more than 150 persons serving on the five HSA governing bodies in Virginia.\* The proposed section would allow HSAs further flexibility in selecting "provider members." The serious lack of meaningful physician-provider representation is a direct result of inadequate specification of provider definition and composition.

The term "direct provider" should be redefined in Section 1531 (3) (A) of the Act and incorporated into the composition requirements specified in Section 1512 (b) (3) (c) (ii). Similarly, the type of provider representation should be specified to include representation by physicians and physician organizations. The proposed Section (Sec. 206 of these amendments) should be significantly altered to reflect specific membership requirements and not an increased ability of the HSA to randomly select provider representatives.

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\* Review of the Proposed Health Planning Amendments of 1978,  
submitted by the Medical Society of Virginia to the Subcommittee  
on Public Health and Environment, February 1, 1978.

Sec. 208 Officials on the Governing Body of a Health Systems Agency

The proposed amendment to Section 1512(b)(3)(c)(iii)(I) is unclear in terms of definition and intent. The precedent apparently established under P.L. 93-641 for HSAs to independently determine membership composition conformity is further promoted in the lack of definition of what constitutes "public and private agencies in the health service area concerned with health." While such flexibility was intended to allow HSAs to emerge through cooperative coalitions of provider and consumer organizations, the absence of meaningful provider input requires additional specification, not further interpretation on the part of HSAs. For example, the broad language in the proposed Section would permit HSAs to indiscriminately select one or more county health departments, hospital associations, mental health and mental retardation entities, PSROs, and local medical societies as constituting "public and private agencies" to be included as governing body officials. The Medical Society of Virginia recommends that entities such as local or county medical societies, hospital associations, PSROs and other organizations be specifically referenced as agencies to be represented on the HSA governing body.

Sec. 210 Return of Health Systems Agency to Conditional Status

Many of the Virginia HSAs have indicated that the restrictive time deadlines for review of HSPs and AIPs are a result of administrative requirements related to designation. These HSAs have noted that they would lose their conditional status if they failed to meet deadlines imposed by DHEW. Thus, the HSAs often fail to incorporate needed changes in their HSPs and AIPs since there are no provisions for extension of time constraints. The proposed Section should be applied to those HSAs who cannot "find the time" to properly revise and/or publicize their HSPs and AIPs. Specifically, the HSAs should be given an opportunity to request extension of their conditional designation status without loss or interruption of funding.



Sec. 216 Proportional Representation of Health Systems Agencies  
on Statewide Health Coordinating Councils

The provision for proportional representation on the SHCC will dilute the ability of HSAs encompassing rural areas to fully participate as equal partners in SHCC deliberations. These HSAs would be seriously penalized for having rural areas within their health service area boundaries. They would become "second class citizens" to the more urbanized HSAs. The interests of their community would become subservient or secondary to the interests of urban-suburban areas. This could extend to decisions regarding the incorporation of rural needs and demands within the State Medical Facilities Plan. Similarly, rural needs for technical assistance involving the funding of studies could be ignored or placed in lower funding priority. Thus, the proportional representation could result in a decreased role for less populated HSAs although community needs could be greater than those of the urban-suburban HSAs.

Sec. 219 Review of Facilities, Equipment, and Services of  
Health Maintenance Organizations

This proposed Section will enable the Secretary to promulgate a separate set of standards and criteria governing the operation of health maintenance organizations. In essence, HMOs will be given preferential treatment. Whether this will work to the advantage or disadvantage of "qualified" HMOs is irrelevant. Each agency, organization, or institution seeking approval from the HSA, SHPDA, and SHCC should have its proposal reviewed according to adequate local data contained in the corresponding HSP, AIP, or State Medical Facilities Plan.

The development of national criteria implemented at the state and local levels is contradictory to the intent of P.L. 93-641. It is the concept of "local" initiative which is basic to the law. This local initiative would be compromised by the promulgation of nationally developed and implemented standards or criteria. The HSA and SHCC are currently involved in the review and subsequent revision of health plans which contain "standards and criteria." The Medical Society of Virginia is assisting the Virginia planning agency community in efforts to modify and adjust standards and criteria to reflect medical needs and concerns. The passage of this proposed section would seriously jeopardize such efforts and the efforts of other provider organizations to promote the credibility of HSPs and AIPs.

The selection of HMOs - it is assumed that the proposed Section relates to federally qualified HMOs - as a separate entity subject to a distinct set of standards and criteria is not in the best interests of the consumers nor providers of health care. Why should HMOs be treated differently? The medical care offered through the HMO setting is a part of a larger system of medical care delivery. To treat the HMO differently from the other health resource delivery entities would tend to fragment the system. Obviously, this is not the intent of P.L. 93-641.

Sec. 220 Technical Amendments

The addition of the term "medical" to Section 1604(b) (1) (I) of the Act further demonstrates inappropriate involvement in medical care delivery issues. Many Virginia HSAs have misinterpreted "technical amendments," national guidelines and standards, and national policy dictates as providing them with a mandate to determine the scope and mode of medical service delivery. The "slight change" which is recommended in the "technical amendments" would provide the planning agency community with additional "evidence" of their right to dictate how medical care should be practiced.

The Medical Society of Virginia has documented evidence of HSA attempts to mandate how and where medical care should be practiced in both the public and private sectors. Such attempts have ranged from specification of the medical care modality to be used in multiphasic screening to promulgation of the number of specialty physicians who should be "allowed" to practice in a health service area. The addition of the term "medical" to the outpatient provisions would set a serious precedent of involvement in medical care issues which is clearly outside the authority and role of planning agencies established under P.L. 93-641.

Sec. 301 Grants to Hospitals to Assist in Discontinuing  
Inpatient Hospital Services

The Medical Society of Virginia has and will continue to support any actions which will improve the quality of health care delivery. However, the use and distribution of public monies by the SHPDA to discontinue hospital services is not warranted at this time. The SHPDA has not demonstrated a capacity to engage in a comprehensive deliberative process which would result in careful evaluation of hospital requests for discontinuance funding.

The addition of the proposed Section would, in essence, encourage the planning agency community to proceed to implement "decertification actions." In fact, one Virginia HSA has, in its HSP, proposed financial sanctions via third party payors to "discontinue unneeded services." Although the proposed Section may appear "voluntary" in nature, its intent is clearly established through its language. Specifically, the HSA and SHPDA may misinterpret and apply the "grant formula criteria" as a "standard" to be used in determination of decertification. While such decertification is not within its scope of authority, the planning agency community may interpret the proposed section as a clear-cut mandate to proceed with their inappropriate and illegal attempts to assume such authority.



The proposed Section allows public or non-profit hospitals in operation for at least seven years to request grants for discontinuance. While the Medical Society of Virginia opposes the proposed Section, it is still unclear why seven years has been selected as a criterion. Years of operation are not necessarily related to the need for discontinuance of services. To establish a minimum number of years further evidences a simplistic approach to issues which impact the quality of inpatient medical care. Such issues can and should be handled through existing Certificate of Need laws which reflect a true concern for health care quality.



AMERICAN OSTEOPATHIC  
HOSPITAL ASSOCIATION

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February 23, 1978

Hon. Paul Rogers, Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D.C. 20515

Dear Mr. Chairman:

This correspondence will express the views of the American Osteopathic Hospital Association on amendments proposed by the Department of Health, Education and Welfare to P.L. 93-641, The National Health Planning and Resources Development Act.

First, the proposal authorizes a grant program beginning in fiscal year 1980 to promote the closure and conversion of unneeded hospital services. This program is designed to provide financial incentives to hospitals to reduce excess capacity or convert it to fill unmet needs. It is our interpretation that this is a compulsory decertification program, although some funds are provided to compensate the facility during the reduction or conversion process.

We are strongly opposed to compulsory decertification. The provision of financial and other incentives is but one element in establishing an environment conducive to voluntary elimination of excess services. However, compulsory decertification raises serious issues such as the abrogation of contracts, deprivation of private property without just compensation, and compliance without due process requirements. In addition, such a proposal can have a serious impact on the rating of hospital bond issues and the general ability of the hospital industry to secure adequate financing for future projects. This Association has contacted representatives of the bond rating companies in various parts of the country. These individuals, and representatives of such organizations as Standards & Poors and E.F. Hutton believe that a decertification program would have a serious and adverse impact on hospital bond ratings and the availability of both financing and refinancing for hospital bond issues.

Therefore, we continue to urge that the Congress encourage the voluntary elimination of excess services and that just and adequate compensation be provided in such a program.

Second, the Administration is recommending the repeal of the current provision in P.L. 93-641 which subjects the establishment of HMOs to certificate of need requirements. HMOs are an integral part of the health care system and as such, should be subject to the same criteria as hospitals and other institutional care facilities. We strongly oppose any exemptions from the certificate of need process, although we would encourage a reasonable modification of the criteria which would take into consideration the unique aspects of this alternative delivery system.

Third, the Administration proposes to require certificate of need decisions to be consistent with state health and medical facilities plans, which must in turn be consistent with the National Guidelines for Health Planning. In our view, Mr. Chairman, this amounts to the elevation of the National Guidelines to a status never envisioned by the Congress--being an official pronouncement of the national health policy which must be followed. While we agree that certificate of need decisions need to be consistent with state health plans and state medical facilities plans, and that there should be some consistency with reasonable national guidelines for health planning, we strongly oppose the concept of giving guidelines the impact of regulations, with a document which is intended to serve as a flexible guideline. We would support an amendment to Section 1513(b) which would make it clear that national guidelines be taken into consideration by HSAs, in the formulation of health plans, rather than be imposed as inflexible, mandatory rules, to be rigidly followed at the local level.

Fourth, the Administration proposes to expand the authority of a public regional planning body or unit of general purpose local government that also serves as an HSA. This proposal would authorize the regular governing board of the parent body to pass on the agency's budget and would approve the Health Systems Plan and Annual Implementation Plan produced by the separate governing body. In addition, there is a proposal to require that HSA governing bodies have at least 25% of their membership drawn from local elected officials. We are strongly opposed to both recommendations. It is our view that the original intent of the Congress in constructing the governing boards of HSAs was, to the maximum extent feasible, to preclude the politicizing of these bodies. While we believe that input from elected officials into the planning process is essential, we do not believe there should be a specifically set aside proportion of the HSA membership for these officials. The underlying philosophy of the planning law is to develop an effective coalition of consumer and provider representatives at the local level. We do not believe that this proposed amendment would support this philosophy. We do, however, support the proposed amendments offered by the American Hospital Association which would assure more direct representation of hospital administration on the governing boards of planning agencies and which would redefine the term "indirect provider" to facilitate the selection of interested, informed, and effective consumer representatives.

Fifth, an amendment is being proposed which would allow HSAs to receive contributions from third party payers. We strongly oppose this amendment on the grounds that it could create a serious conflict of interest. Third party payers have a direct interest in the decisions HSAs may render with regard to the various plans and applications for certificates of need. We therefore strongly recommend the defeat of this amendment.

Sixth, we are very concerned with a series of proposed amendments which would 1) replace the per capita and minimum grant funding mechanisms with greater discretion for the Secretary to set funding levels of HSAs; 2) permit secretarial discretion to redesignate health service areas upon finding that a new area is more appropriate and that there are good reasons for change; and 3) that would permit the

Secretary to return an HSA to conditional status after it has been fully designated, if that HSA is not performing its functions adequately. This series of amendments would place sufficient power in the hands of the Secretary of HEW to significantly alter the current concept embodied in P.L. 93-641 that health planning should be primarily a state and local undertaking. These amendments would create an atmosphere conducive to interference with local planning initiatives which could undermine the entire planning program. We are therefore strongly opposed to each of these proposals.

In conclusion, Mr. Chairman, the Administration is seeking to create an over-emphasis in the health planning program on cost containment rather than a balance among quality, accessibility and cost containment which P.L. 93-641 encourages. This is a view which this Association does not share and we would be pleased to comment further on those matters addressed above.

Sincerely,

*Gerson I. Cooper*

Gerson I. Cooper, Chairman  
Government Relations Committee

cc: Subcommittee on Health and the Environment

## association of american medical colleges

February 23, 1978

Honorable Paul G. Rogers  
Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
2415 Rayburn House Office Building  
Washington, D.C. 20515

Dear Mr. Chairman:

The Association of American Medical Colleges -- which represents all of the nation's medical schools, sixty-three academic societies, and over 400 major teaching hospitals -- appreciates this opportunity to add to its previous testimony on health planning the following comments on the amendments proposed by the Department of Health, Education, and Welfare.

The AAMC continues to endorse the positions and observations contained in the Association's January 31st testimony on H.R. 10460. In addition the Association wishes to comment on three particular DHEW proposals: the overly broad financial discretion proposed for the Secretary, the binding authority proposed for state medical facilities plans, and the proposed changes in governing board composition.

Section 212 of the HEW proposal eliminates formula grants for HSA funding and states that "the amount of any grant. . . shall be determined by the Secretary." When this proposed section is combined with Section 101 where authorization levels are proposed as "such sums as may be necessary," it becomes clear that DHEW is proposing to consolidate all funding decisions at the Federal agency level. The legitimate Congressional role of using authorizations and funding formulas to ensure program equity and diversity would be eliminated by these proposed revisions. In addition, because HSA's are dependent upon their financial funding for survival, consolidation of funding at the DHEW level threatens the local autonomy of HSAs by making their economic future absolutely dependent upon the financial decisions and leverage of the Secretary. Therefore, the AAMC is opposed to the unspecified authorizations of Section 101 and the elimination of formula grants of Section 212 of the Administration's health planning proposal.

Section 214 of the DHEW proposal requires that a certificate of need may be granted only where a proposed project is consistent with the state medical facilities and state health plans. The proposal would create a serious "Catch 22." Unless new technologies are introduced, in at least limited numbers, there will be no experience on which to base planning guidelines and decisions. Innovations must be introduced, used, and

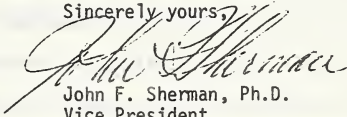


evaluated to determine their usefulness, and HSAs must have sufficient latitude to permit such innovations in the absence of documented guidelines. Therefore, the AAMC recommends that health systems and state health plans be required to include provisions for the introduction of new medical devices and innovations which must be deployed in limited numbers to evaluate their clinical usefulness and cost effectiveness. Moreover, the AAMC recommends that the Secretary of HEW be required to perform or commission studies on approaches to the introduction, deployment, and cost-benefit analysis of expensive new medical technology.

Section 208 of the Administration's proposal would require that at least one quarter of each HSA's membership consist of government representatives. This requirement -- when added to governing board requirements for consumers, providers, rural representatives, and others -- could place HSAs in an overly restrictive situation where the required mix of board members was difficult to obtain or required that disinterested government officials be solicited for board membership. Therefore, the AAMC, while not opposed to the inclusion of government officials on HSA governing boards, is opposed to establishing a requirement that a percentage of HSA governing board members be government representatives.

If you have any questions regarding these comments, or if I or other members of the Association's staff may be of further assistance to you in this matter, please do not hesitate to call upon us.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "John F. Sherman". The signature is fluid and cursive, with the first name "John" being particularly prominent.

John F. Sherman, Ph.D.  
Vice President

cc: Honorable David E. Satterfield III



**Consumer Coalition  
for Health**

"Consumers United for  
Better Health Care through  
Effective Planning"

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Washington, D.C. 20005  
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February 23, 1978

COMMENTS ON PROPOSED AMENDMENTS TO P.L. 93-641 BY THE  
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Section 203 is a highly undesirable proposal because it would impede, if not substantially remove, the independence of the governing body for health planning in public HSAs. Subsection (c) would gut the entire notion of a separate governing body for health planning by requiring approval of the health systems plan and the annual implementation plan by the public body or unit of local government. Since these plans are to be the basis for all other planning decisions, the proposed amendment would move the effective control of health planning away from what was intended by the statute, from a broadly representative consumer-provider group to an agency of local government. It would mean that rather than an independent governing body for health planning, we would have what is essentially an advisory board with the true decision-making power resting in the unit of local government. Effective control would be in a body which does not meet the broadly representative requirement of the act.

The process of undermining the independent health planning body would be further increased by granting powers to remove members of that body to the unit of local government and by making the budget of the agencies subject to approval by the local governmental unit. Although local

governments might properly wish to exercise control over how health funding provided by them is utilized, they should not have control over the federal funding. In effect, such control allows the public governmental body to dictate to the agency how its resources should be used and will have the effect of making the staff of the agency more concerned about the wishes and desires of the governmental unit than of the members of the supposedly independent governing body for health planning to which staff should be accountable.

It is also unclear what, if any, is the purpose of the amendment to the first sentence of section 1512(b)(3)(A), as proposed in Section 203(a).

Section 205 would remove the twelve month period during which indirect providers are prohibited from serving as consumers on HSA bodies. This provision would be counter-productive to its intended purpose. In practice, it would permit the hospital trustee or a member of a board of directors of a pharmaceutical manufacturer to become a so-called consumer representative merely by resigning from the board of the hospital or pharmaceutical company. Although we recognize that there may be cases where legitimate consumer representatives on the governing bodies of health care institutions are prevented from serving on HSAs, we believe that the effect of the proposed amendment would be primarily to allow persons with primary identification with provider institutions to serve under the guise of a consumer. For the handful of legitimate consumer representatives who

might serve on HSA boards under this amendment, we will have hundreds of provider representatives serving under a consumer classification.

Section 208(b) is a highly desirable provision to the extent that it provides for separate representation of public elected officials and other representatives of government authorities. However, the Consumer Coalition for Health believes that the percentage of the board allocated to that group in the HEW proposal, namely 25%, is too high, and should be reduced to 15%, the current level of participation by public officials. According to the testimony of HEW Undersecretary Hale Champion before this Committee, public elected officials and their representatives now constitute 15% of HSA boards. Of this number, 68% are classified as consumers. For the reasons spelled out in more detail in the statement of Herbert Semmel submitted to this Committee on behalf of the Consumer Coalition for Health, pages 12-14, the effect of the current practice is to dilute consumer representation. At the same time, serious questions arise as to whether public officials are providers or consumers and the proposed amendment would eliminate that ambiguity. We support a provision for 15% of the board to be public elected officials and other representatives of governmental authority, retaining the current requirements for a consumer majority as set forth in the HEW proposal.

Section 209 is undesirable because it would permit funding of HSAs by any health care insurer. As is shown in Professor Sylvia Law's book "Blue Cross: What Went Wrong", there is an historical connection between health care provider institutions and Blue Cross and Blue Shield. Although this connection is no longer as strong at the national level and even at some state levels, there are other areas where the close relationship between Blue Cross and Blue Shield and providers still continues. The cost-consciousness of some health care insurers is commendable, but even this can create conflicts with community needs for additional health services. Moreover, insurers may be oriented to a particular type of insurance, such as hospitalization, whereas community needs may call for other kinds of services. The ban on funding of HSAs by insurers should be continued. Insurers are at least indirectly affected by HSA decisions.

Section 212 would destroy the independence of HSAs by giving too much power over their budgets to the Secretary of HEW. HSA staff, concerned about their funding, might be too interested in pleasing bureaucratic officials at the regional and national levels of HEW and give less priority to responding to local community health needs.

Section 213(a) is desirable since it includes new major medical equipment under mandatory certificate of need coverage, but does not go far enough. Major capital expenditures by physicians for construction of offices and other facilities, for home health agencies, and for leasing and new acquisitions should be included in certificates of need.



Section 213(c) appears to remove health maintenance organizations from mandatory federal certificate of need requirements. The Consumer Coalition for Health supports this deletion, with one exception. We believe that certificates of need should be retained for new hospital construction by HMOs but denial of certificates of need at the state level should be subject to review and final decision by the Secretary of HEW in the case of closed panel, federally qualified HMOs. A second problem with this subsection is that it does not make clear whether states will remain free to include HMOs in state certificate of need legislation. In the HMO legislation, Congress clearly indicated its intention to encourage the development of HMOs. In many situations, HMOs have demonstrated their ability to provide quality comprehensive health care at substantially lower cost than the fee-for-service basis. Federal policy should not be undermined by restrictive approaches in state certificate of need legislation or decisions. The proposed HEW amendments do not appear to change the authority of HSAs to review and approve federal grants under the federal HMO legislation. It is not clear whether this is intended or whether it is the result of an oversight.

Section 214 is a desirable provision in strengthening the planning function in requiring coordination with state health plans. However, similar coordination should be required with the regional health systems plan developed by the HSA. Otherwise this proposal would undercut the notion

of the HSA as the basic planning unit and would encourage the state agency to ignore the recommendations of the regional planning agency in the area directly affected by a certificate of need application.

Section 218 contains a totally undesirable provision which eliminates public hearings when the governor does not approve the first state plan submitted by the SHCC. The effect of such a provision would mean that the final state plan which is approved would never have been available to the public in advance or commented upon by the public. What this really means is that the plan will unfold through private back door bargaining between the governor and the SHCC.

Section 219(a)(2) is unclear. Why is the reference to health maintenance organizations deleted here if HMOs are still subject to review and approval or even review and comment by either HSAs or state agencies.

Section 219(a)(4) is unclear as to which sentence would be stricken by this provision.



HEALTH  
SYSTEMS  
AGENCY  
OF  
SAN DIEGO  
AND  
IMPERIAL  
COUNTIES

A  
PUBLIC  
REGIONAL  
HEALTH  
PLANNING  
BODY

February 23, 1978

The Honorable Paul G. Rogers  
Chairman, Health and Environment  
Subcommittee of the Interstate  
and Foreign Commerce Committee  
2415 Rayburn House Office Building  
Washington, D.C. 20515

My dear Mr. Rogers:

In a letter dated February 14, 1978, Representative David Satterfield invited me to comment on the proposed amendments to Public Law 93-641. As President of the Governing Body of the Health Systems Agency of San Diego and Imperial Counties (California District 14), I would like to submit the following comments on these amendments.

Because of time constraints, I have not had the opportunity to consult with our Governing Body or its legislative committee on all of the issues covered by the proposed amendments. In each of the following responses, it has been noted whether the comments reflect the President's opinion, or formal action by the Governing Body.

This letter will be submitted to the Governing Body for review at its next meeting on February 24, 1978, which is also the deadline date for receipt of comments. Therefore, this letter is being sent in order to meet the deadline, and you will subsequently receive a follow-up report of the Governing Body's position on these comments.

It should be noted that these comments do not necessarily--and I am sure in some instances will not--represent the views of the Governing Board of the Health Systems Agency of California District 14.

Following are my comments on the proposed amendments by section:

Section 201. Should continue to require the Governor's request before division of an HSA. (President's opinion).

Section 202. There should be concurrence of the Governor before the boundary of an HSA is changed. (President's opinion).

Section 203. In an unanimous action, our Governing Body took action opposing the provision to transfer to the parent body (Governing Board) the power to approve the budget of the separate governing body for health planning, the Health Systems Plan, and the Annual Implementation Plan. I quote from this action taken on January 27, 1978:

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714 / 297-4721

...."that the President of the Health Systems Agency of San Diego and Imperial Counties be directed to encourage the maintenance of the status quo of Public Law 93-641 as relative to the hiring of the Executive Director, approval of the Health Systems Plan and the budget."

By statute, the Governing Body was set up to be broadly representative of the local community as the designated health planning agency. The Governing Board is usually made up of busy local governmental officials who can not and have not participated in the long and important discussions essential to plan development. Because of the multitude of responsibilities carried by these governmental officials, it would be impossible for them to be totally knowledgeable about the budget of the Agency, the Health Systems Plan, and the Annual Implementation Plan. We believe that the present 'review and comment' provision is the appropriate role of the Governing Board in these matters. Let me add that at present, our Agency personnel rules and policies do require approval of the Governing Board. This procedure has worked well, and we would support this change. (It should be noted that the above unanimous opinion of the Governing Body has not been concurred in by the Governing Board of California District 14.)

Section 204. Support of this proposal is offered. (President's opinion).

Section 205. No opinion.

Section 206. No opinion.

Section 207. Support of this important amendment is offered. Non-metropolitan groups need to be able to have more representation than that equal to population. (President's opinion).

Section 208. Opposition to this proposal is submitted, on the grounds that this provision will restrict the memberships of HSAs materially. It assumes that governmental representation is more important than the diverse groups mandated by the present law. A 10-15% membership of representatives of governmental authorities might be reasonable. 25% is far too great. (President's opinion).

Section 209 - 210. No objection.

Section 211. This proposal is supported. This type of budgeting seems more reasonable since it would eliminate last minute spending at the end of a fiscal year and would allow for more appropriate use of the funds in the following year. (President's opinion).

Section 212. This provision is opposed. It will involve these budgets in 'log-rolling' and both the Secretary and the HSAs have more important matters to deal with. (President's opinion).

Section 213. This essential amendment is strongly supported. (President's opinion).

Section 214. Such a provision is necessary in order for health planning to accomplish anything. Strongly agree. (President's opinion).

Section 215. No comment.

Section 216. There should be a dual system in which both HSA representation and population are considered. In California for HSAs with population over some figure such as 2,000,000 add representatives for each increment. (President's opinion).

Section 217. This proposal is supported. It will provide the Governor with more influence over health planning. (President's opinion).

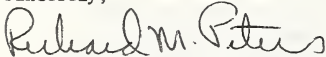
Section 218. This provision needs clarification. It is not stated what would happen if the Governor doesn't act or does not approve the Plan. (President's opinion).

Section 219. This provision is opposed because it disregards local conditions. (President's opinion).

Title III is supported. This provision is essential if we are to correct any of the many anachronisms resulting from previous poor planning and ineffective regulations.

Thank you for the opportunity to comment on these proposed amendments. After the Governing Body's review of these comments, I will notify you of the outcome.

Sincerely,



Richard M. Peters, M.D.  
HSA President

RMP:vc

cc: Supervisor Taylor, Chairperson, Governing Board District #14  
Members Governing Body District #14  
Members Governing Board District #14  
Representative David E. Satterfield III



PUBLIC CITIZEN HEALTH RESEARCH GROUP  
 COMMENTS ON HEW DRAFT BILL TO AMEND  
 THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT  
 FEBRUARY 23, 1978

The Health Research Group has previously submitted extensive comments on H.R. 10460 and S. 2410, copies of which are enclosed. Many of the provisions of the HEW draft bill are the same as or similar to provisions in the House and Senate bills. Rather than repeating those comments here, we will merely refer the Subcommittee to the section of our previous comments on each topic. In most cases where an HEW provision is not included in either bill or is substantially different, however, we have made additional comments. Following is a section-by-section analysis of the HEW bill:

Section 101. We oppose the exclusion of further authorization for the Area Health Services Development fund, which, although no funds have yet been appropriated for it, has the potential for facilitating implementation of high priority projects, such as preventive and primary care programs, identified by HSAs. It is the only authority under which HSAs can themselves encourage development of new services rather than merely disapproving the offering of services by others, and thus can be a means for gaining public support. We are pleased that both the House (§§101(f), 224(e)) and the Senate (§205) bills extend authorization for section 1640. The Subcommittees must also support adequate appropriations for the Area Health Services Development Fund.

Section 201. We oppose any provision which makes it easier to split multi-state Standard Metropolitan Statistical Areas into multiple HSAs. The Washington, D.C., area is an example of how such splitting cripples effective health planning.

Section 203. We oppose granting public planning bodies or local governments authority over HSA budgets and plans and removal of board members for the same reasons that we opposed appointment of the HSA board by the overall board. See Senate comments (§107).

Section 204. We suggest that the exception for personnel records be limited to clearly unwarranted invasions of employees' personal privacy. See Senate Comments (§109).

Section 205. See House comments (§209(d)(1), #2, bottom of page 2) and Senate comments (§110).

Section 206. We have no objection to broadening the representation of providers but suggest that representation of non-professional workers (as in Senate bill §113) and free-standing ambulatory clinics (other than physicians' offices) be required.

Section 207. See House comments (§209(b)(2), #1, top of page 2) and Senate comments (§114).

Section 208. The requirement that public officials constitute at least 25 percent of the HSA governing body is the most significant departure in the HEW bill from the House and Senate bills and from P.L. 93-641. We support the reduction in provider representation to less than 25 percent. All providers have inherent conflicts of interest and should play only an advisory role in the HSA. Also, providers have the resources to influence HSAs by means other than board representation.

We also have no objection to mandatory representation of public officials on the HSA board. However, we do not believe that a special category should be created. Public officials should have to meet the same selection and composition requirements as other board members, and all should be either consumers or providers. If clarification of their provider or consumer status is needed, we suggest that persons serving on bodies of general purpose local government be classified as consumers (even if the government unit operates health programs or facilities), while persons who administer governmental health programs be classified as providers. Both categories should have some representation and together they should constitute at least 10 percent of the board (an upper limit would be inappropriate).

Overall, the board should be at least 75 percent consumers and no more than 25 percent providers. This approach is similar to that of §209(b)(1) of the House bill.

Section 209. We strongly oppose this provision. See House comments (§208, #1, bottom of page 2).

Section 210. We support granting HEW authority to return HSAs to conditional status. See Senate comments (§§127, 130). This provision is superior to that in the House bill (§205).

Section 213. We support coverage of medical equipment in all settings and elimination of discrimination against HMOs. However, equipment costing less than \$150,000 also should be covered under certain circumstances. See House comments (§218(b), ##8, 9, page 1) and Senate comments (§141).

Section 214. See House comments (§218(a), #7, page 1) and Senate comments (§118(b)). In testimony before the House Subcommittee on this amendment, HEW Undersecretary Champion said that "State health and medical facilities plans...must... be consistent with National Guidelines" (page 18), even though such a requirement is not explicit in either P.L. 93-641 or in the recent proposed regulations on national guidelines published by HEW. We support this interpretation of the statute and urge that it be made explicit by amendment of §1524(c)(2)(A).

Section 218. We strongly oppose giving the Governor veto power over an SHP which has been approved by the SHCC. See Senate comments (§118(c)).

Section 219. We oppose the exemption of HMOs from any review criteria developed by HSAs and SHPDAs pursuant to P.L. 93-641, including those which go beyond minimum Federal requirements. It may be appropriate to require HSA and SHPDA review to be "consistent with" the section 1306(c) criteria (as the law already does). However, planning agencies should not be precluded from using other review criteria (such as those related to quality of care) which are consistent with P.L. 93-641 and don't conflict with but are not required under section 1306(c), so long as they are also applied to fee-for-service providers. In other words, Federally-qualified HMOs should neither be discriminated against nor given preferential treatment. It is reasonable to avoid subjecting HMOs to conflicting requirements and to certificate of need review which doesn't apply to their competitors. The former was achieved by the 1976 HMO Amendments, and the latter would be accomplished by proposed amendments (HEW §213(b)-(c)). No further amendment is necessary or desirable; this section should not be enacted.

Section 221. The effective date under §221(a) should be within 90 days rather than 180 days. See House comments (§225, #4, top of page 3).

Section 301. We generally support the concept of grants to discontinue inappropriate services in certain circumstances. However, such a program must be more closely integrated with other planning reviews. See Senate comments (§206). Also, there is no reason why eligibility should be restricted to hospitals which have been in operation more than seven years. The provision (§301(a)) should be eliminated.

#### Provisions Missing From HEW Bill

Many crucially important problems with the health planning program are not addressed at all by the HEW bill. Several provisions in the House and Senate bills at least partially remedy some of these problems. Following is a list of the most important of these amendments. More details about each of these proposals are contained in our comments on the House and Senate bills.

1. Most HSA boards do not comply with the statutory requirement that consumer members be broadly representative of the population because HEW has failed to enforce the law and to publish promised regulations. See House comments (#1, page 3).

2. HSA board members are also unrepresentative because the boards are self-initiated and self-perpetuating. The statute must require an open selection process. See House comments (§210, #3, page 1, and #2, page 3) and Senate comments (§106).

3. Consumers in HSAs need full time staff support and technical assistance. See House comments (§213, #3, top of page 2) and Senate comments (§148).

4. Changes in the structure and procedures of HSAs such as required hearings on the Annual Implementation Plan, conflict of interest provisions, and required consumer majorities, open meetings, public notice, and data disclosure for all HSA committees must be mandated. See House comments (§§212(b), 214, 216(e); #4-6, page 1) and Senate comments (§§104, 115, 119(b)).

5. The State Health Planning and Development Agency must have a consumer majority and fixed terms. See House comments (#5, bottom of page 3) and Senate comments (#3, page 7).

6. A moratorium on non-emergency capital expenditures until the SHPDA is fully designated must be imposed. See House comments (#7, page 4) and Senate comments (#5, page 8).

7. Federal facilities should be subject to HSA and SHPDA review. See House comments (#8, page 4) and Senate comments (§141).

The enclosed comments discuss several other proposed amendments which are not adequately addressed in any of the three bills.



TEXAS HOSPITAL ASSOCIATION

6225 U.S. Highway 290 East — Mailing Address: P.O. Box 15587, Austin, Texas 78761 — A.C. 512-453-7204

February 23, 1978

The Honorable Paul G. Rogers, Chairman  
 Subcommittee on Health and Environment  
 Committee on Interstate and Foreign Commerce  
 2415 Rayburn House Office Building  
 Washington, D.C. 20515

ATTENTION: Bob Crane

Dear Congressman Rogers:

On behalf of its almost 600 member hospitals, the Texas Hospital Association wishes to thank you for the opportunity to provide comments on the proposed "Health Services Amendments and Hospital Services Discontinuance Act of 1978".

The THA has long supported the basic concept of planning as envisioned in P.L. 93-641. We believe that planning is a cornerstone in the process of health care delivery and that only when it is effective at the local level can we expect meaningful results.

As envisioned in the current Act, planning for services by the local health systems agency is the first step in a careful evaluation of the "needs" of the population served. In order that this may be accomplished, alternative objectives must be developed, along with methods for their accomplishment. Then, through a careful process of screening, revision and evaluation, those alternatives which will best meet the needs of the public to be served may be identified.

This process must be locally initiated and directed based on the needs of the local population. Rigid, quantitative standards, developed at the national level, are unworkable and politically unpalatable, deter initiative, slow the advance of technology, and cannot reflect the diversity which exists within our country.

Specifically, we wish to offer the following comments:

1. Section 1511(b)(4) -- This section would extend the authority of the Secretary to redesignate Health Service Area boundaries on his own volition without the concurrence of the Governor of the State. We oppose such an intrusion into the state and local decision making process. This provision should be deleted.
2. Section 1512(b)(3)(A) -- As a result of this proposed change, the governing body of any HSA which was designated under an agreement with either a unit

Texas Hospitals: Official Monthly Journal

Affiliates: Texas Hospital Education and Research Foundation, and Texas Hospital Association Health Services Corporation



of general local government or a public regional planning body would be required to seek the approval of its parent organization on its budget, Health Systems Plan and Annual Implementation Plan, and with regard to the removal of members of the separate governing body for good cause.

The removal of these three areas from the authority of the HSA governing body will undermine that board's effectiveness. In fact, when these three prerogatives are removed, the purpose for the separate governing body is questionable.

We support the philosophy of having representatives of governmental entities on HSA boards, but cannot believe that the removal of the board's basic management responsibilities will do anything but hinder the planning process.

3. Section 1512(b)(3)(B)(viii) -- We support the concept that personnel records be held confidential and not subject to public disclosure.
4. Section 1512(b)(3)(C)(i) -- We support the clarification of the definition of "indirect provider" to exclude persons, who, because of service on the board of trustees of an institution, for example, have been incorrectly classified.
5. Section 1512(b)(3)(C)(ii) -- Although we support representation on HSA boards, which is reflective of the interest and concerns of all providers of health care services, we urge Congress to reevaluate this section and more clearly delineate the requirement for representation from health care administration on HSA and SHCC boards.

Because hospitals are the primary focus of this legislation, it is imperative that those who are most heavily impacted be represented in order that the agency board may be accurately informed from the hospital viewpoint. Although physicians are the key to hospital admission, these direct providers often are not involved in hospital operation. Further, although elected officials are direct representatives of the "public" because of their positions, the key to understanding and adjusting the delivery system is the person or persons who direct the operation of institutions for the delivery of services. It is therefore imperative that these institutions be directly represented on HSA boards in a manner which reflects the number of institutions and their bed capacity.

6. Section 1512(b)(3)(C)(iii)(II) -- We support the proposed change as its intent seems to be to allow an HSA board to determine the urban/rural mix of that body in a manner which best serves that area's needs.
7. Section 1512(b)(3)(C)(iii)(I) -- We support representation on HSA boards by elected officials and other representatives of governmental authorities in the Health Service Area as these persons are in positions which to some degree assure their responsiveness to the public electorate. However, we



urge that rather than requiring that one-fourth of the HSA board membership be elected officials and other such representatives of government authorities, that the law be amended to provide that the number may not exceed one-fourth of the membership. This would allow the local agency to be responsive to local conditions and needs.

8. Section 1515(c)(3) -- We find it difficult to perceive why an HSA would need to return to conditional designation status after having once been fully designated, provided that HEW is properly monitoring and consulting through its regional offices and regional centers for health planning. We believe such to be preferable to termination without adequate notice.

Further, we believe that provisions requiring formal notice by the Secretary during the process of review, at least six (6) months and again three (3) months prior to a decision to return an agency to conditional designation or termination, clearly spelling out deficiencies, should be provided to assure that agencies are informed of their status.

9. Section 1531(5) -- While we generally support the requirement that major medical equipment costing in excess of \$150,000 be reviewed as a part of a state certification of need program, we find incredible that health maintenance organizations would be excluded from these requirements. We therefore oppose the exclusion of HMO's from this section.
10. Section 1523(a)(4) -- Although we support the concept that the state certificate of need program should take into account the State Health Plan and State Medical Facilities Plan, we find it impossible to live with a requirement for "consistency".

As the term "consistent with" is subject to interpretation and the SHP and SMFP may not reflect up to date developments in medical technology, for example, we urge that these documents be used as references and that the wording be changed to provide that certificates of need may be issued for projects or equipment not included in these plans when they reflect the justified needs of the area to be served.

11. Section 1523(a)(5) -- We question the purpose for the elimination of this section as it seems to further erode the clarity of the relationship between state agency and the HSA in review of proposed new institutional health services.
12. Section 1524(b)(1)(A) -- We object to elimination of the requirement for equal representation for each HSA on the SHCC. We believe that the SHCC should be a body which is representative of the agencies with which it must coordinate. The health care needs of all persons residing within the state are of equal concern, regardless of their place of residence.

To establish the makeup of the SHCC on the basis of population would, we believe, skew the representation in Texas and in many other states by placing

the majority of the representatives in major population areas.

13. Section 1524(b)(1)(A)(i) -- We believe that the nomination process should remain as provided in the current Act.
14. Section 1524(b)(2) -- We concur fully with this proposed change.
15. Section 1524(c)(2)(C) -- We concur that the SHP should be approved by the Governor if the plan is to truly be the "state plan". We believe that any plan, once rejected by the Governor, must be resubmitted to him for final approval and once approved, those who participated in public hearings as well as the public at large should be informed of the change. Although a public hearing is not necessary, in our view, the public must be informed.
16. Section 1532(c) -- We do not believe that Section (c)(8) should be eliminated. The addition of (d) seems contrary to the intent of the Act in that it provides for a special review process for one element of the delivery system. For planning to be effective and strengthened through "need review", it must apply equally to all segments of the system.
17. Section 301, Title III -- The subsections covering grants to health care facilities which propose to cease operation or which propose to discontinue a service contain several provisions which we find unrealistic and outside the scope of a "planning process". These include:

Subsection (a) -- This would provide that only facilities which have been in operation seven years would be eligible for grants. If the intent is to assist the closure of any facility or service which proposed to voluntarily close, no such restrictive limitation should be imposed.

Subsection (b) -- The Secretary would prescribe the form of application, its manner and process of submission and content. We believe that Congress should specify the process, content, and information required and allow the Secretary to develop the form.

Subsection (c) -- The term "appropriateness" is used in subsections (a) and (c). As this term is yet undefined and such provision in P.L. 93-641 has caused great concern among all elements of the planning process, we believe that it should be removed.

Subsection (d) -- Provision is made in this subsection for grants by the Secretary if he determines that three conditions are met. All three of these proposed requirements are ludicrous.

For example, it would be impossible to determine that average per capita hospital cost in the Health Service Area would be less as a result of the facility or service ceasing operation. In addition to the fact that a single facility is unlikely to substantially affect the cost of care in a Health Service Area, such may be difficult, if not impossible, to calculate

as the accumulation of all elements of cost to be considered will be a formidable task.

Unlike the steady flow of propaganda from HEW that would have the Congress and public believe that curtailment or merger inevitably leads to lower per capita costs, evidence pointing to just the opposite -- increased costs -- under some such curtailments actually ensue. An empty bed, merged services, and forced lowering of quality and public convenience do not necessarily lead to cost savings even though the expense may be shifted from one group or government to another.

Finally, no facility which has participated in any other federal program, due to the unending strings which are always attached and the fact that no determination is final if the Secretary wants to change his mind, is likely to accept such a grant.

Subsection (e) -- The proposed grant amounts are unrealistic if the Congress is sincere in its wish to assist facilities to liquidate debts upon closure.

The provision for "net" debt liquidation is unrealistic as it will result in valid debts of facilities being determined to be outside what the Secretary considers other than "reasonable".

Subsections (f) and (g) -- Provisions which allow the Secretary to determine the time and method of payment as well as the requirements for records, audits, and the like seem to leave a great deal of discretion in the administration of this program to the Secretary. Although we believe that he should have latitude within which to operate, we believe there should be more clarification of the intent of Congress in this area.

The following concerns are raised by the THA pertaining to issues not addressed in the DHEW proposal. As earlier described, this Association has long been a strong supporter of the health planning process and, in fact, endorsed a state certificate of need legislative proposal long before P.L. 93-641 was enacted. Because we support meaningful planning and want to see that the process at the state and local levels prospers, we would like to suggest the following additional amendments to P.L. 93-641 to improve the planning function:

1. Section 1513(b)(2) -- There should be clarification of the relationship between Guidelines, National Goals, Standards and Benchmarks. Further, the term "consistent with" should be deleted.

It is imperative that amendments to the law be provided which will make it clear that planning activities are to be conducted primarily at the local level, with minimum interference from either the state or federal governments. Rigorous requirements imposed from "top down" do not permit viable planning; they authorize centralized, dictatorial control. We do not believe this to be the Congressional intent, but it is obvious that HEW wants to assume such authority.

Further, we believe that Section 1501(b)(2) which provides for the development by HEW of "A statement of national health planning goals.... to the maximum extent practicable.... in quantitative terms," requires revision.

The term "quantitative" in the present law is being used by HEW to issue guidelines that would be implemented as "rigid standards". To date, the Department of HEW has issued two proposed drafts of the National Guidelines for Health Planning as well as proposed Guidelines for the Development of State Medical Facilities Plans. These proposals contain rigid formulas which are based on scientifically unproven methodologies that fail to take into account numerous variables which cannot be held constant. Clearly no formula is perfect, and the guidelines should state that there are limitations in the use of a formula.

2. Section 1533(d) and 1502(g) -- This Association is concerned with the provisions of the Act which require the Secretary to develop a uniform hospital cost accounting system.

The health care industry is not different from other industries as far as uniformity and standardization of financial reporting are concerned. For years the American Institute of Certified Public Accountants (AICPA) through its Accounting Principles Board and now the Financial Accounting Standards Board has endeavored to develop generally accepted accounting and financial presentation. With the aid of the AICPA's Hospital Audit Guide and the American Hospital Association's Chart of Accounts of Hospitals, there has been direction provided for uniformity and consistent application of principles.

THA does not believe that a uniform accounting system developed by the government and its use mandated by the government is either appropriate or will be productive.

Hospital accounting systems are designed to account for and report as appropriate for the individual institution the financial results from total operations. It should be remembered that the hospital exists to serve all patients, not just those receiving benefits under federal or state insurance programs. It is, therefore, inappropriate for the government to mandate for all hospitals a rigid "uniform accounting system" of its own design. The accounting system employed by the individual institution must remain within its own discretion bound only by generally accepted accounting principles and designed to accurately present its own financial condition.

The more appropriate objective should be the development of a meaningful uniform reporting system. Within the basic framework of accepted accounting principles and a basic chart of accounts, the individual hospital will be able to report data as required by a uniform report.

Therefore, we strongly recommend the Act delete the Secretary's charge to develop a Uniform Hospital Accounting System.

3. Section 1513(e)(1) and (2) -- We believe that review activities of HSA's should be limited to recommendations and comments on proposals for certificate of need and/or federal grants. The HSA's were established as planning bodies and, therefore, should not be in the business of initiating the development of any proposed facility or service which they might later be required to review and disapprove under current responsibilities.

We therefore urge the Congress to enact an amendment to this legislation to provide for state determination of grants upon review and recommendation of the health systems agencies.

4. Section 1532(b) -- The Association supports a 90 day review process for both certification of need and Section 1122 programs. Further, such an amendment should provide that when the review is not completed in the 90 day statutory period, the application will otherwise be deemed approved. This would bring both the certificate of need and the Section 1122 review programs within the same "approval by silence" rule.
5. Section 1513(b) -- This Association supports an amendment to ensure that HSA's do not perform functions, or are not required to attempt to perform functions, beyond the capabilities and/or resources of the agency. We recommend a revision to the Act which would permit fully designated HSA's to phase in functions as they acquire the financial and staff resources to carry out such responsibilities. We therefore urge your consideration of this most important revision.
6. Section 1524(b)(1)(C) -- The composition of the SHCC, an agency with great responsibility at the state level, requires review as pointed out earlier in this letter. Therefore, it is sufficient at this point to state that adequate representation by hospital administration on this body must be assured. We would therefore propose that no less than two (2) such members be required.
7. Section 1513(g)(1) and (2) and Section 1523(a)(6) -- As previously stated, this Association believes that the Appropriateness Review provisions of the statute are unnecessary and should be deleted.

The sections referenced previously have not been defined by HEW. We believe that this is a reflection of the difficulties created by this provision. We find it difficult to believe that this will ever be accomplished and should therefore be reconsidered.

We believe that effective planning and certificate of need processes are the answer to the problem of duplicative facilities and services, not a review process which cannot be defined, nor administered.

8. Section 1602 -- We believe that the federal government should adopt a single set of constructive codes and standards for the physical requirements of hospitals and other institutional providers of health care services. These should be applied uniformly to all federal programs by a single agency or



department. Therefore, necessary revisions to the statute must be adopted to bring about such a reorganization.

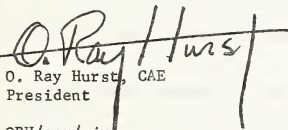
9. Sections 1516(b)(1)(2)(B) and (3) and 1512(b)(5) -- We believe that revisions are needed to provide financial resources to health system agencies which will allow them to perform the functions required by the law.
10. Section 1534 -- The THA supports revisions to the Act which would eliminate artificial barriers between hospitals and HSA's created by contractual requirements such as those imposed upon Regional Centers for Health Planning and HSA's which prohibit anyone other than a member of an HSA board from attending educational or other sessions conducted by these agencies. Such conditions give the HSA the aura of secrecy and this does not foster cooperation.

Experience has shown that coordination and cooperation between HSA and hospitals are essential if planning is to work. Therefore, all potential barriers which are created by statute or action of federal agencies must be eliminated.

If we have a plea that runs throughout this document, it is that Congress is our last vestige of hope as HEW, without any accountability, has demonstrated that we are at their mercy.

Thank you again for the opportunity to comment on the proposed revisions to P.L. 93-641. If we may be of assistance to you, please call upon us.

Sincerely,

  
O. Ray Hurst, CAE  
President  
ORH/cer/sjr  
Enclosure

- P.S. Attached is a memorandum given me on February 22 in response to my request for comments by the Texas Health Facilities Commission, a Commission, incidentally, that was established pursuant to the Texas Act implementing P.L. 93-641.



## TEXAS HEALTH FACILITIES COMMISSION

AUSTIN, TEXAS 78731

## COMMISSIONERS

Melvin Rowland, Chairman  
 Rensl B. Rossen, Vice Chairman  
 P. Bolin Mahaffey, Member

M E M O R A N D U M

TO: Melvin Rowland  
 Chairman

FROM: William D. Darling *W.D.D.*  
 General Counsel

DATE: February 22, 1978

SUBJECT: Proposed H.E.W. Amendments to Public  
 Law 93-641--Preliminary Review

I have received a copy of the draft of H.E.W.'s proposed amendments to Public Law 93-641. A few of the proposals are so substantially harmful to the delivery of health care in Texas that I am preparing this preliminary report. This initial report will deal only with the most onerous provisions in the amendments with a complete report to follow.

Section 202 of the draft Bill proposes to amend Section 1511(b)(4) to read as follows:

"(4) The Secretary shall review on a continuing basis and at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that a boundary for a health service area no longer meets the requirements of subsection (a), or a change in the boundary of such area would result in a health service area which better meets the requirements of such subsection, he may revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(ii) for the establishment of boundaries of health service areas which include areas not included in boundaries submitted by the Governors. If the Secretary acts on his own initiative to revise the boundaries of any health service area, he shall consult with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate health systems agency or agencies designated under part B and the appropriate Statewide Health Coordinating Council established under part C. A request for boundary revision shall be made only after consultation with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate designated health systems agencies, and the appropriate established Statewide Health Coordinating Council and shall include the comments concerning the revision made by the entities consulted in requesting the revision."

This section gives the Secretary unbridled authority to change the boundaries of HSAs within a state without actually establishing a legitimate purpose. The Secretary might use this provision to punish HSAs that did not fall into line with national guidelines, etc. The amendment on its face appears rather innocuous, but an HSA and a state might be continually harassed by boundary changes at the whim of the Secretary. Changes in HSAs boundaries can only lead to poor health planning and confusion among providers. I can see no other purpose in this amendment other than to give the Secretary more control over the actions of local HSAs.

Section 214 of the proposed amendments would alter Section 1523(a)(4) of the Public Law to read as follows:

"Serve as the designated planning agency of the State for the purpose of Section 1122 of the Social Security Act if the State has made an agreement pursuant to such section, and (B) administer a state certificate of need program which applies to new institutional health services and new major medical equipment proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such a program shall provide for review and determination of need prior to the time such services, facilities, and organizations equipment are offered or developed or substantial expenditures are undertaken in preparation for such offering or development and provide that only those services, facilities, and organizations equipment found to be needed and consistent with the State Health Plan under this Title and the State Medical Facilities Plan under Title XVI shall be offered or developed in the State. In performing its function under this paragraph the state agency shall consider recommendations made by health systems agencies under Section 1513(f)."

This amendment appears to be the final step in H.E.W. attempting to put a total federal lock on the planning and regulatory process under Public Law 93-641. The introduction to the initial draft of the national guidelines included the statement that:

"It should be noted that each State's Health Plan developed under Title XV of the Public Health Service Act must be made up of the Health Systems Plans for areas within the State, which in turn must take into account and be consistent with the National Guidelines. Health Systems Plans also provide one of the bases for the development of the State Medical Facilities Plan required under Section 1603. Thus, it is expected that the National Guidelines will be reflected in the development of State Health Plans and State Medical Facilities Plans.

In addition, regulations issued concerning the certificate of need function (42 CFR Chapters 122 and 123) cite consistency

with the Health Systems Plan for an area as one criterion for review of new institutional health service projects. Thus, it is anticipated that the National Guidelines will also be addressed in the criteria adopted by HSAs and SHPDAs governing review activities under certificate of need, the review of new institutional health services, and other mandated reviews."

This amendment is another indication of the total lack of understanding by H.E.W. of due process requirements under the Fourteenth Amendment. The addition of this amendment would mandate not only that an applicant establish that "need" has been established for a project within the criteria set out but would also require consistency with the State Health Plan (SHP) and State Medical Facilities Plan (SMFP). This amendment overlooks the possibility that an SHP or SMFP might be arbitrarily and capriciously designed. State courts will not uphold the denial of a certificate of need based solely on the fact that it is inconsistent with one of the two plans. If an SHP or SMFP is arbitrarily drawn to exclude a needed project, state courts will not hesitate to reverse the decision of the state agency. H.E.W. must realize that it cannot draft regulations and guidelines from Washington to control the delivery of health care within the State of Texas or any other state. Ultimately the final decision-making authority will rest with local individuals. The continual amendment of Public Law 93-641 and the issuance of guidelines and regulations that attempt to place a federal stranglehold on the program of health planning and cost containment can only result in the ultimate rejection and subversion of the program by states.

Section 219 of the proposed amendments is as least as bad if not worse than Section 214. Section 219 amends Section 1532(c) of the Act to read as follows:

"(c) Except as provided in subsection (d), criteria for health system agency and State Agency review shall include consideration of at least the following:

- (1) The relationship ...
- (2) The relationship of services ...
- (3) The need that the population ...
- (4) The availability of alternatives, ...
- (5) The relationship of services reviewed ...
- (6) In the case of health services ...
- (7) The special needs and circumstances ...

~~(8) --The special needs and circumstances of health maintenance organizations for which assistance may be provided under title XIII.~~

(9)(8) In the case of a construction project-- ...

(d) Criteria required by subsection (a) for health systems agency and State Agency review, in relation to the facilities, equipment, or services of health maintenance organizations (as defined in section 1301), shall include only those criteria specified by the Secretary, and shall be consistent with the standards and procedures established by the Secretary under section 1306(c).

This provision represents another attempt by H.E.W. to take over the ultimate decision-making authority from the states and to exercise the police power denied them by the Constitution. Adoption of this amendment by Congress would be a statement to states that "you have failed in your attempt at cost containment and health planning" before the process is even off the ground. We have already seen from the national guidelines that H.E.W. cannot properly draft regulations that take the uniqueness of individual states into consideration. We should not expect them to do any better in drafting a set of criteria for each state to follow.

These comments are preliminary in nature, and I will review these proposed amendments in detail as time permits. A complete discussion of the amendments will be prepared for your review. I hope that upon subsequent review I will not be as alarmed by the amendments outlined in this memorandum as I am at the present time. H.E.W. is apparently attempting to place states in a position of superimposing an inflexible regulatory program over its existing state laws. The fact that some state laws will not easily mesh with the federal law and regulations, especially in procedural matters, creates problems in implementation of the federal law. To assume that states may easily amend existing laws to comply with the federal law fails to recognize the dynamics of state politics. The Secretary should promulgate regulations and attempt to amend the federal law in such a manner which will give state government the latitude to establish programs which are adequate to achieve the goals of Public Law 93-641 and function within the framework of state law.

WDD:ms



**Blue Cross®**  
Association



Regional Office  
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Washington, D.C. 20006  
202/785-7900

February 24, 1978

Honorable David Satterfield  
Room 2348  
Rayburn House Office Building  
Washington, D. C. 20515

Dear Mr. Satterfield:

This letter responds to your request for comments on the specific amendments to P.L. 93-641; the National Health Planning and Resources Development Act, proposed by the Department of Health, Education and Welfare.

Our overall reaction to the proposed amendments is favorable. We have the following comments related to specific proposed amendments.

A number of proposed amendments relate to HSA funding, i.e., to decrease fiscal year 1979 authorization levels (Section 101); to allow the Secretary of HEW greater latitude in the determination of appropriate grants for individual HSAs (Section 212); and, to permit insuror contributions to HSAs (Section 209).

In the aggregate, current HSA funding levels appear to be adequate to accomplish the functions currently required of such agencies under P.L. 93-641; however, we understand that problems are being encountered by small agencies funded at the minimum level of \$175,000. Further, it is possible that geographic factors and economies of scale achieved in larger agencies may need to be taken into account in the determination of appropriate funding levels. Accordingly, we support the proposed amendment to increase the Secretary's authority to establish planning grants unique to each HSA.

The general adequacy of federal funding levels, suggests that an increased allowance for contributions is unnecessary. With no empirical evidence to the contrary, we, therefore, recommend that the Act not be amended to allow insuror contributions. Instead, we recommend that the Act clearly specify that HSAs are allowed to provide services at cost to local persons and entities on a contract basis, with the stipulation that HSAs not be allowed to enter into such contracts with direct providers of care. Such contract allowances have the primary benefit of enabling the HSA to respond to local health planning issues on a timely basis even when exploration of such issues cannot be accommodated within the limits of the agency's federal funding.

Section 208 of the proposed amendments would require that at least one quarter of each HSA's membership consist of representatives of governmental authorities and, we understand, would also apply the current provision concerned with consumer representation only to consumers who are not such representatives. The critical issue in HSA governing body composition is that it consist of a balanced representation of broad community and provider interests and perspectives. Accordingly, we feel that the current requirement that a majority of all governing body members be consumers be maintained, and that governmental representation in the consumer and provider categories should continue to be flexible, varying among HSAs based on unique needs and circumstances. While the participation of representatives of governmental authorities is desirable and should be encouraged, P.L. 93-641 should not establish either "floor or ceiling" requirements concerning such representation.

Section 213 would expand federally approved CON program requirements to include major medical equipment acquisitions, regardless of setting and would eliminate the requirement that such CON programs determine the need for the establishment of health maintenance organizations (HMOs). First, both the Blue Cross Association and the Blue Shield Association are deeply concerned with the problem of artificial shifts in the provision of services between hospitals and other providers in order to circumvent regulatory controls. Specifically, the present national experience with the introduction of major medical equipment, for example, the CT Scanner, suggests that a variety of mechanisms should be employed to prevent abuse of the health planning process.

To address this problem, we support the proposed extension of state CON program controls to include capital expenditures for major medical equipment, regardless of setting. The Blue Shield Association has taken a position in support of the use of the reimbursement mechanism to provide strong incentives or sanctions to prevent the proliferation and unwarranted utilization of such equipment.

Second, we do not support the proposed exemption of HMOs from state CON programs. Rather the Planning Act should provide that alternative delivery systems, such as HMOs, are subject to no more, and no fewer, CON controls than are imposed on capital expenditures sponsored by providers in the traditional health delivery system. At the same time, we recognize that in some instances potential problems may arise where an HMO's intent to use existing inpatient care of other facilities on a contract basis may be thwarted. Thus, such an HMO may be forced to propose a capital expenditure to provide such services. To address this potential problem, we recommend that the Act's provision for "special consideration" review criteria with respect to HMO applications be maintained, with the intent of Congress strictly expressed on this matter. This provision further helps to insure that HMOs are treated equitably while, at the same, it provides the public with the opportunity to examine the merits of the individual planning processes of such entities.

Section 214 of the proposed amendments would require a state, before granting a certificate of need, to determine that the project was consistent with the State Medical Facilities Plan (SMFP) and the State Health Plan (SHP). We endorse the spirit of this proposed amendment; however, we recommend both that

that the plan development process be simplified by eliminating the SMFP and that CON program decisions on individual projects be consistent with the SHP.

We also recommend that the State Health Plan (SHP) be required to meet SMFP requirements--particularly with respect to the ranking of needed services. Also, the Health Systems Plan (HSP) development provision should be amended to assure that goals are both ranked and expressed in terms of their capital and operating cost implications. Thus, the results of the planning process would be expressed through two key plans, the HSP and SHP--each of which would rank goals and objectives. Since these Plans generally have a 5 year planning horizon, each should contain a one year component similar in structure and content to the non-required AIP.

Sections 217 and 218, respectively, would direct the Governor of a state to appoint the Chairman of the SHCC and would subject the State Health Plan developed by the SHCC to approval by the Governor. We recommend either that these amendments be withdrawn or that the Governor's existing authority, (i.e., to appoint directly 40% of the SHCC membership and to appoint, based on lists of persons submitted by HSAs, the remainder of SHCC membership) be substantially reduced. If the proposed amendments were adopted without modification of the existing SHCC member selection provision, we do not believe that an effective system of "checks and balances" at the state level will be accomplished in the development of the SHP.

Title III of HEW's proposed amendments would establish a federal grant program to assist hospitals to discontinue unneeded inpatient services. We generally favor such a program; however, we have the following concerns with the specifics of the proposed program.

First, the program should not require the individual hospital requesting assistance under this Title to seek and receive a finding of "inappropriateness" from the SHPDA respecting the services proposed to be discontinued. Since HEW has not yet even promulgated proposed rulemaking on appropriateness reviews, and we are aware of no agencies which are currently performing such a function, it is unrealistic to expect HSAs and SHPDAs to be performing such reviews, particularly of individual providers, in the near future. Accordingly, we recommend that the HSA should be required only to review the proposed discontinuance as part of its authority to review the proposed use of federal funds within its area and make its recommendation to the Secretary.

Second, the requirement that the hospital receiving a Title III grant "comply with such additional conditions as the Secretary determines are appropriate" should be either eliminated or defined such that the limits of the Secretary's authority are more clearly set forth.

Third, Title III should be applicable only to complete closures of hospitals, with the financial requirements of partial closures and conversions being met through the provider payment mechanism, with all payers required to recognize the fixed costs associated with conversion or partial closure.

Also, Title III should require that an individual hospital's grant payment be reasonably equivalent to the institution's long term indebtedness (up to, but not exceeding, the undepreciated book value of plant and equipment assets), less the sum of the value of other assets in excess of other liabilities and the salvage value of physician plant and equipment. Further, a reasonable allowance for severance pay should be added, where necessary, to the grant payment.

I hope that our comments are helpful to you in your deliberations. If I can be of any further assistance, please let me know.

Sincerely,

Neil Hollander  
Vice President  
Health Care Services

cc: Honorable Paul Katers

# Health Industry Manufacturers Association

1030 Fifteenth St., N.W.  
Washington, D.C. 20005  
(202) 452-8240

February 24, 1978

Honorable Paul G. Rogers, Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D.C. 20515

Attention: Bob Crane

Dear Mr. Rogers:

The Health Industry Manufacturers Association is pleased to respond to the invitation of Congressman Satterfield to comment on the proposed HEW amendments to P.L. 93-641, the Health Planning and Resources Development Act of 1974. The Association's comments on this proposal are, in general, similar to those presented in our testimony to your subcommittee on H.R. 10460.

As noted in our statement of February 2nd, the manufacturers of medical devices and diagnostic products support the concept of health planning with emphasis on the local level. Moreover, the renewal and extension of the planning law offers a valuable opportunity to acknowledge and facilitate the benefits of cost-effective medical technology in national health goals and resource management. Regrettably, the draft bill does not address this issue.

The Association has advanced five suggestions for planning law amendments designed to heighten the awareness of medical technology and the contribution it can make to cost effective health care planning. None of these suggestions is reflected in the draft bill. The bill is deficient because:

1. It does not amend Section 1502 on national health priorities to include as an enumerated goal the affirmative responsibility of the health planning system to foster the prompt and reasonable utilization of cost effective medical technology in planning and resources development.
2. It does not create planning conditions favorable for research through different standards for considering major medical equipment purchases or capital expenditures in connection with research activities.

An association representing the medical device and diagnostic product industry



3. It does not make express provision in the definition of indirect providers for medical technology manufacturers to be eligible for representation on HSA governing bodies.
4. It does not amend Section 1503 on the National Council on Health Planning and Development to require that at least one member be a representative of indirect providers knowledgeable about the cost effectiveness of medical technology.
5. It does not reduce existing obstacles in the planning system to facilitate the replacement of obsolete or less cost-beneficial medical technology.


The draft bill also suffers from a premature judgement on the employment of certificate of need conditions apart from new institutional health services. Specifically, the bill would dramatically expand the certificate of need scope to any purchase of major medical equipment in non-institutional settings. We believe that this approach is not necessary to correct any abuse of the existing planning process that may be now perceived. Moreover, this new authority is likely to overburden the planning system with decisions and procedures of only marginal importance to fulfilling local health needs. The draft bill makes useful administrative changes to facilitate the efficiency of the planning system. In contrast, the expansion of the certificate of need program could seriously erode these gains by multiplying the workload of a typical HSA. The expanded certificate of need authority is premature and should be avoided in order to allow the system to concentrate on planning for institutional services.

The Association supports the concept of Title III of the draft bill to provide grant assistant to hospitals for discontinuing inappropriate inpatient services. This concept is preferred to the provisions of Section 219 of H.R. 10460 which would appear to mandate, through the requirement for a decertification program, prompt discontinuance of an inappropriate service without any "winding down" assistance. The draft bill avoids any substantive changes in existing law on appropriateness review. Until such time as the untried mechanism of appropriateness review has shown some capacity to deal usefully with health service oversupply, the Association believes that the present terms of Section 1523 should not be expanded.

The preceding comments have been offered for consideration of the subcommittee as it prepares for mark-up sessions on H.R. 10460 and associated bills. The Association is preparing a series of suggested amendments to H.R. 10460 consistent with our testimony for the subcommittee's consideration. These amendments will be submitted within the next few days.

We appreciate this opportunity provided by you and Congressman Satterfield to assist the subcommittee, and we look forward to constructive participation in the weeks ahead.

Sincerely,

  
Harold O. Buzzell  
President

HOB/pl

## HOSPITAL FINANCING STUDY GROUP

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John Nuveen & Co.,  
Incorporated

## Vice Chairman:

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February 24, 1978

Honorable Paul G. Rogers, Chairman  
Subcommittee Health and The Environment  
Committee on Interstate and Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D. C. 20515

Attn: Bob Crane

Dear Congressman Rogers:

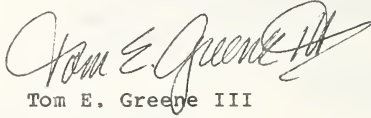
The Hospital Financing Study Group is pleased to take advantage of the extra 10-day opportunity which your Subcommittee has allowed for commenting on the Administration's version of the amendments to the Health Planning and Resources Development Act of 1974.

Our enclosed Supplemental Statement to the Subcommittee focuses exclusively on the Administration's bill. We feel that the earlier version of the health planning amendments, H.R. 10460, while generally an excellent proposal, is flawed in one respect. It would allow health facilities, particularly hospitals, to be decertified and put out of business without providing for any retirement of the outstanding indebtedness on the institution. As we pointed out in our testimony before the Subcommittee on January 31, 1978, forcing a hospital out of business without at the same time retiring its debt would leave the investors who have financed the bonds which made the hospital possible in the first place in a most disadvantageous position.

Title III of the Administration's bill, on the other hand, takes a different approach. The Administration's bill would allow financial assistance to those hospitals which are either closing down altogether or are converting a part of their

facilities to some other health care use. We generally feel that, from an investment banking standpoint, the best approach to reducing excess hospital capacity is to provide financial assistance for those hospitals which undertake either facility closure or facility conversion.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "Tom E. Greene III", with a stylized flourish at the end.

Tom E. Greene III

TEG/al  
Enclosure

SUPPLEMENTAL STATEMENT OF  
THE HOSPITAL FINANCING STUDY GROUP  
TO  
THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
OF THE  
HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE  
CONCERNING H.R. 11077, THE NEW VERSION OF THE  
"HEALTH PLANNING AND RESOURCES DEVELOPMENT  
AMENDMENTS OF 1978"

FEBRUARY 24, 1978



The Hospital Financing Study Group was privileged to testify before this subcommittee on January 31, 1978, concerning H.R. 10460, Congressman Rogers's proposed "Health Planning and Resources Development Amendments of 1978." Tom E. Greene III of Lehman Brothers Kuhn Loeb spoke for our Group.

At that time we took a position, one which we still hold, in general support of Congressman Rogers's bill. We continue to support all rational proposals to strengthen the local health planning process. We particularly support efforts to reduce the problem of excess hospital capacity which, in the view of many, has helped to drive up health costs at an unacceptable rate. But we felt constrained to point out in our statement of January 31, that section 219(b) of Congressman Rogers's bill represents only one-half of a workable solution to the problem of excess capacity. That section would, in effect, require each state to convert its "appropriateness review" into a mandatory "decertification" within four years. We do not oppose decertification in concept. But, as investment bankers, we expressed our opinion that decertification, standing by itself, would devastate the market for hospital bonds. No rational investor will sink his money into 30-year bonds to finance a hospital capital project when the hospital itself can be closed down by a decertification decision 5, 10, or 15 years down the road. The consequence of decertification, standing alone, would be a major increase in the cost of financing needed hospital renovation and modernization or resort to federal direct subsidy of capital needs.

Decertification makes sense only if it is linked with a "retirement payment," that is, with a system for funding the outstanding debt, equity and other transitional costs which spring up when a hospital is closed down or converted to another use. Without this security, private capital will not remain in the hospital bond market in sufficient quantity and the cost of hospital capital that is available will soar. But when firmly linked with a retirement allowance, decertification offers to the reimbursement system the best of both worlds: reasonably priced financing for needed capital projects plus the flexibility to retire existing hospital plants which are no longer needed. We are convinced that decertification, when linked with an equitable payment program, will save money for the reimbursement system.

In light of the above, the HFSG favors those proposals in which the process of reducing excess hospital capacity is associated with paying off the outstanding debt on facilities being retired, for example, Title III of this subcommittee's H.R. 9717 or section 3 of Senator Talmadge's S. 1470. Similarly, we look with favor on Title III of H.R. 11077, the Administration's version of the health planning amendments. This Title places the initial burden on the hospital which has excess inpatient capacity to make a request for financial assistance with the costs of shut-down or conversion. If the state health planning agency finds that the particular inpatient service

which the hospital wants to discontinue is no longer "appropriate" then the hospital becomes eligible for financial assistance in handling the costs of discontinuing this service.

Title III takes an approach to the problem of excess hospital capacity which we favor and support. Title III links service discontinuance with retirement payments, a linkage which, from our perspective as investment bankers, is essential. We should note in passing that Title III suffers from one defect which we urge the subcommittee to remedy: it does not adequately deal with the problem of debt retirement when a hospital is closing down only a portion of its facilities. Section 301(e) of the Administration's bill states as follows:

(e) The amount of any grant under this section shall be determined by the Secretary. A grant under this section may include amounts--

(1) in the case of the closure of the entire hospital, to liquidate the net outstanding debt of the hospital,

(2) in the case of conversion of part of the hospital from use for inpatient care to another health care use, to pay for the costs of that conversion, including costs of construction, . . . .

The first clause of this subsection authorizes funds for debt retirement when a hospital wholly closes. The second clause authorizes payments for the "costs of . . . conversion" when a hospital converts part of its facility to another health care use. Thus, the first clause would deal with one situation (total facility closure) while the second clause would deal

with another (partial conversion to another health care use). But neither of them deals adequately with a third situation: closure of part of a hospital without conversion to another health care use. This third type of situation could easily arise. For example, a hospital might be significantly overbedded and might wish to shut down a wing. But if the other health care uses to which the wing might be converted were already provided in the community, the hospital could ill afford to do anything but leave the wing open. If it closes the wing, it no longer receives any revenues to support that wing's share of its overall capital costs. If, on the other hand, it converts the wing to a non-health care use, then Title III would give it no financial assistance with the conversion costs. In short, the bill, as drafted, has overlooked the problem of partial facility closure.

We believe that this oversight can be corrected by adding a phrase to the first clause of § 301(e) of Title III. It should read:

(e) The amount of any grant under this section shall be determined by the Secretary. A grant under this section may include amounts--

(1) in the case of the closure of the entire hospital, to liquidate the net outstanding debt of the hospital, and in the case of the closure of part of the hospital, to liquidate that portion of the net outstanding debt of the hospital which is attributable to the portion of the hospital which is being closed, . . .

We believe that the intent of Title III, to create ultimate reimbursement savings by reducing excess capacity, will be furthered by the change we are suggesting.

In sum, then, the HFSG generally supports the Administration's H.R. 11077 as a valuable proposal for strengthening the local health planning process. We believe that ways must be found to free the reimbursement system of the fiscal drag of unneeded hospital facilities. We also believe that any plan for closing or converting excess hospital capacity must provide financial assistance for the costs of shut-down, including the costs of retiring outstanding debt. Otherwise, the hospital bond market will disappear and the costs of financing hospital capital projects will soar. In light of the above, we favor Title III of the Administration's bill and view it as a distinct improvement over section 219(b) of H.R. 10460, Congressman Rogers's version of the health planning amendments. Title III is the right approach to take. We do, however, suggest that it be strengthened by allowing for partial debt retirement in the case of partial facility closure, as well as for full debt retirement in the case of full facility closure.



**KAISER  
FOUNDATION**  
HEALTH PLAN, INC.

KAISER CENTER • OAKLAND, CALIFORNIA 94606, PHONE 415 / 271-2211

EXECUTIVE OFFICES, ORDWAY BUILDING

February 24, 1978

The Honorable Paul G. Rogers, Chairman  
Subcommittee on Health and the  
Environment

Committee on Interstate and Foreign  
Commerce

Room 2415, Rayburn House Office Bldg.  
Washington, D. C. 20515

Attn: Bob Crane

Dear Congressman Rogers:

Congressman Satterfield has requested our comments on the amendments to Public Law 93-641 proposed by DHEW. Our comments are limited to the proposed amendments which will have an impact upon health maintenance organizations (HMOs).

The proposed amendments represent an attempt to deal more equitably with the problems which P. L. 93-641 creates for developing and established HMOs. However, we believe that the amendments we submitted to you achieve this objective in a more appropriate manner. Specifically:

1) §213 would eliminate HMOs from the definition of new institutional health services and would include major medical equipment under the certificate of need requirement. However, the provision ignores the fact that a substantial number of states cover HMOs under their existing certificate of need laws as a direct result of the requirement that is contained in P. L. 93-641. These states should conform their certificate of need laws to the federal requirements as proposed in our amendments A-1 and B-1. In addition, we believe major medical equipment used substantially by HMO members should be exempt from the certificate of need requirement as set forth in our amendments A-2 and B-2.

2) §214 would require that projects must be consistent with the State health plan and the State medical facilities plans under title XVI before they can be approved. However, the plans may not cover

the subject of the application for a certificate of need. We have experienced this situation a number of times. Therefore, this provision should be changed so that projects may be approved if they are not inconsistent with the plans as proposed in our amendment 9.

3) §219 would repeal the requirement that HSAs and State Agencies consider the special needs and circumstances of HMOs and replace it with a requirement that they apply criteria to HMOs which will be developed by the Secretary. This approach has merit, but we prefer our proposed amendment B-4. However, if the Administration's approach is used, we believe the criteria should be set forth in the Act. We propose the following substitute for §219(d) if HMO health facilities and equipment are covered by the certificate of need requirement:

"(d) Projects which will provide substantial services to members of health maintenance organizations shall be approved if they involve remodeling, modernization or replacement of existing facilities, equipment or services to meet the needs of such members; or if they involve new facilities, equipment or services, unless the appropriate health systems agency and the State Agency determine that the services to be provided by such a project are available from an existing health care facility on a long-term contractual basis under circumstances in which an adequate number of physicians in appropriate specialties who are associated with the health maintenance organization have full and equal staff privileges and in a manner which is economically and clinically feasible for the health maintenance organization."

This provision is consistent with the comments in the Conference Report on the HMO Amendments of 1976 (Attachment A).

4) The proposed amendments do not require the HSP and the State health plan to contain HMO elements. Such requirements are provided for in our amendments 6, 7 and 8.

5) The proposed amendments do not provide that an HMO can appeal an adverse decision to the Secretary as set forth in our amendment 10.

6) The proposed amendments do not limit HSAs to review and comment with regard to grants, loans and loan guarantees under the HMO Act as does our amendment 11.

7) The proposed amendments do not conform §1122 of the Social Security Act to proposed amendments to P. L. 93-641. Our amendments A-5 B-5 do so.

We appreciate the opportunity to comment on the proposed amendments.

Sincerely yours,

KAISER FOUNDATION HEALTH PLAN, INC.

By: James A. Lane  
James A. Lane  
Vice President and Counsel

rsb  
Attachment

cc: Members of Subcommittee  
Health and the Environment  
Hale Champion  
Henry Foley, Ph.D.  
Frank Newman, M.D.  
James Doherty

94TH CONGRESS } 2d Session }	HOUSE OF REPRESENTATIVES {	REPORT No. 94-1513
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## HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1976

SEPTEMBER 13, 1976.—Ordered to be printed

Mr. STAGGERS, from the committee of conference,  
submitted the following

### CONFERENCE REPORT

[To accompany H.R. 9019]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 9019) to amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

#### SHORT TITLE; REFERENCE TO ACT

*Section 1. (a) This Act may be cited as the "Health Maintenance Organization Amendments of 1976".*

*(b) Whenever in title I an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.*

#### TITLE I—AMENDMENTS TO TITLE XIII OF THE PUBLIC HEALTH SERVICE ACT

##### SUPPLEMENTAL HEALTH SERVICES

*Sec. 101. (a) Section 1301(b) (1) is amended by adding at the end the following: "A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2), in the basic health services provided its members for a basic health services payment described in the first sentence."*

*(b) The first sentence of section 1301(b) (2) is amended by striking out "the organization shall provide" and all that follows in that sentence and substituting "the organization may provide to each of its*

cipients on a prepaid risk basis. This concern was the source of the two changes in the Senate amendment agreed to by the Conferees. Additional concern was expressed about the impact of the change brought about by the Senate amendment on existing demonstration projects, such as the one underway in Newark, New Jersey. Since the demonstration project authority in section 1115 of the Social Security Act is unchanged by the amendment, and continues to allow the requirements of section 1902 to be waived and the requirements of section 1903 to be overridden in determining expenditures of section Federal matching, these demonstration projects, and other projects which are designed as legitimate demonstrations of new and previously undemonstrated ways to deliver health care more effectively to Medicaid recipients, would not be endangered.

#### RELATIONSHIP BETWEEN HMO'S AND HEALTH PLANNING PROGRAMS

##### *Applicability of Certificate of Need*

*Existing Law:* Specifically includes HMOs in the definition of "institutional health services" in section 1531(5) of the PHS Act. This subjects HMOs by law to the certificate of need process required by title XV in every State.

*House Bill:* No change.

*Senate Amendment:* Deletes reference to HMOs from the definition of institutional health services. This has the effect of subjecting those specific services of HMOs which are institutional health services as defined in regulations of the Secretary to certificate of need but not the specific services of HMOs which are not institutional health services nor the establishment of the HMO itself. Section 16(a) of S. 1926.

*Conference Substitute:* Conforms to the House bill. The Conferees noted that the entire subject of certificate of need for outpatient and ambulatory services in both prepaid and fee-for-service settings will be considered next year when P.L. 93-641 is reviewed for extension. Thus it was felt that it would be more appropriate to deal with inclusion of HMOs under the requirements of the planning act at that time.

##### *Consistency in Procedures and Criteria*

*Existing Law:* Section 1306(c) of the PHS Act requires the Secretary to establish standards and procedures for areawide and State health planning agencies to follow in reviewing HMO applications for assistance under title XIII. Section 1532 requires areawide and State health planning agencies to follow procedures and criteria, developed and published in accordance with regulations, which criteria are to include criteria respecting the special needs and circumstances of HMOs for which assistance is available under title XIII.

*House Bill:* No change.

*Senate Amendment:* Requires the criteria established by areawide and State health planning agencies under section 1532(c) to be consistent with standards and procedures established by the Secretary under section 1306(c). Section 16(b) of S. 1926.

*Conference Substitute:* Conforms to the Senate amendment, because although the procedures and criteria required of health planning programs by P.L. 93-641 were required to include special consideration of the needs and circumstances of HMOs, this provision was not enlarged



upon or specified in any way in regulations published by HEW. The Senate amendment would assist in correcting this situation because the standards and procedures established by the Secretary under section 1306(c) would be the responsibility of the HMO program rather than the health planning program.

Specification of criteria for HMOs is of critical importance because projects for the development and expansion of HMOs and their services should be judged on the basis of the need for HMOs and the need for their services for their enrolled members and reasonably anticipated new members and not on the need for the services in general if proposed by non-HMO providers.

Thus, in considering requests for new HMOs or the expansion of existing ones, the State agency and the health system agency should consider:

1. The number of HMOs of the same type in the area,
2. The number of persons in the area enrolled in qualified HMOs of the same type, and
3. The percentage of major employers and all employers of over 25 employees in the area which offer or will offer qualified HMOs as benefits for their employees.

In considering requests by HMOs to provide or arrange for new institutional health services, the agencies should consider whether the proposed service is available from non-HMO providers in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In making such a determination, the agencies should consider:

1. Whether the alternative service would be more costly to the members of the HMO.
2. Whether the alternative service would be available to the members of the HMO on a long-term basis, and
3. Whether the alternative service would be available and conveniently accessible through physicians and other health professionals associated with the HMO. (For example, whether physicians associated with the HMO are granted full staff privileges at the hospital which is proposed to provide the alternative services.)

Proposals to provide new institutional health services, after feasibility of an HMO has been demonstrated, should not be subject to re-determination, subsequent reviews, public hearings, etc., at later stages of activity, if the proposals are consistent with the basic objectives, schedule and plan of the earlier application approved by the HSA. Similarly, certificate of need determinations should be made during the planning stage of the HMOs development. This is to prevent up to \$1 million of initial development funds being awarded only to have a certificate of need denied, or the need for an HMO questioned by antagonistic groups late in the HMO's developmental sequence.

#### REQUIREMENTS FOR PUBLIC HEARINGS ON THE PART OF THE SECRETARY

*Existing Law:* No requirement.

*House Bill:* No requirement.

*Senate Amendment:* Requires the Secretary to conduct public hearing within the area which will be served by an applicant for HMO

February 24, 1978

Amendments To  
H. R. 10460

Alternative A

A-1. Amend §218(b)(2) to read as follows:

(2) The second sentence of Section 1523(a)(4) is amended to read as follows:

"Such program shall provide for review and determination of need prior to the time such services are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services found to be needed shall be offered or developed in the State, but shall not provide for review of or determination of need for health maintenance organizations or entities which provide substantial services to members of health maintenance organizations."

A-2. Amend §1531(7) as added by §218(b)(3)(A) to read as follows:

"(7) For purposes of section 1523 and 1527, the term 'major medical equipment' means medical equipment which is used for the provision of medical and other health services and which costs in excess of \$150,000, except medical equipment used to provide substantial services to members of health maintenance organizations."

A-3. Add §1531(8) to §218(b)(3)(A) to read as follows:

"(8) For purposes of sections 1523 and 1527, the term

'health care facility' does not include a health care facility used to provide substantial services to members of health maintenance organizations."

A-4. Add §1531(9) to §218(b)(3)(A) to read as follows:

"(9) The term "provide substantial services to members of health maintenance organizations" means to provide at least seventy-five percent of all services to persons who are members of health maintenance organizations."

A-5. Add §226 to read as follows:

SEC. 226. (a) Section 1122(a) of the Social Security Act is amended by striking "or health maintenance organizations".

(b) Section 1122(b)(1) of the Social Security Act is amended by striking "or health maintenance organization".

(c) Section 1122(b)(2) of the Social Security Act is amended by striking "or health maintenance organizations".

(d) Section 1122(d)(1)(B)(ii)(I) of the Social Security Act is amended by striking "or health maintenance organization".

(e) Section 1122(d)(2) of the Social Security Act is amended to read as follows:

"(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health

care facility would discourage the operation or expansion of such facility or a health maintenance organization which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title V, XVIII, or XIX, he shall not include such expenses pursuant to paragraph (1).

(f) Section 1122(h) of the Social Security Act is amended by inserting before the period the following:  
 "or to health care facilities which provide at least seventy-five percent of their services to members of health maintenance organizations"

Alternative B

B-1. Amend §218(b)(2) to read as follows:

(2) The second sentence of Section 1523(a)(4) is amended to read as follows:  
 "Such program shall provide for review and determination of need prior to the time such services are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services found to be needed shall be offered or developed in the State, but shall not provide for review

of or determination of need for health maintenance organizations or entities used to provide substantial services to members of health maintenance organizations, except health care facilities."

B-2. Amend §1531(7) as added by §218(b)(3)(A) to read as follows:

"(7) For purposes of section 1523 and 1527, the term 'major medical equipment' means medical equipment which is used for the provision of medical and other health services and which costs in excess of \$150,000, except medical equipment used to provide substantial services to members of health maintenance organizations."

B-3. Add §1531(8) to §218(b)(3)(A) to read as follows:

"(8) The term "provide substantial services to members of health maintenance organizations" means to provide at least seventy-five percent of all services to persons who are members of health maintenance organizations."

B-4. Add §218(b)(7) to read as follows:

(7) Section 1532(c)(8) is amended by adding at the end thereof the following:

"Health care facilities projects which will be used to provide substantial services to members of health maintenance organizations shall be approved if they involve remodeling, modernization or replacement of existing



facilities or services to meet the needs of such members; or if they involve new facilities or services, unless the appropriate health systems agency and the State Agency determine that the services to be provided by such a project are available from an existing health care facility on a long-term contractual basis under circumstances in which an adequate number of physicians in appropriate specialties who are associated with the health maintenance organization have full and equal staff privileges and in a manner which is economically and clinically feasible for the health maintenance organization."

B-5. Add §226 to read as follows:

SEC. 226. (a) Section 1122(a) of the Social Security Act is amended by striking "or health maintenance organizations".

(b) Section 1122(b)(1) of the Social Security Act is amended by striking "or health maintenance organization".

(c) Section 1122(b)(2) of the Social Security Act is amended by striking "or health maintenance organizations".

(d) Section 1122(d)(1)(B)(ii)(I) of the Social Security Act is amended by striking "or health maintenance organization".

(e) Section 1122(d)(2) of the Social Security Act is

amended to read as follows:

"(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility would discourage the operation or expansion of such facility or a health maintenance organization which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title V, XVII, or XIX, he shall not include such expenses pursuant to paragraph (1).

6. Amend §216(c)(3) to read as follows:

(3) Section 1524(c)(2) is amended by inserting "as determined by the State Agency of the State" after "state-wide health needs" each place it occurs and by inserting before the period at the end of the first sentence the following: "and which shall contain a health maintenance organization element which shall identify the number and type of health maintenance organizations and providers which provide substantial services to members of health

maintenance organizations, the extent to which health maintenance organization facilities and equipment are in need of modernization, and the extent to which health maintenance organizations and health maintenance organization facilities and equipment need to be developed or expanded."

7. Amend §216(d) to read as follows:

(d) Section 1513(b)(2) is amended by inserting after the first sentence the following:

"The HSP shall also include a statement of changes (through increases or reductions, or both) in personnel, facilities, and other resources which the agency determines are required to meet the goals set forth in the preceeding sentence and shall contain a health maintenance organization element which shall identify the number and type of health maintenance organizations and providers which provide substantial services to members of health maintenance organizations, the extent to which health maintenance organization facilities and equipment are in need of modernization, and the extent to which health maintenance organizations and health maintenance organization facilities and equipment need to be developed or expanded."

8. Amend §216(f) by redesignating it as §216(g) and add §216(f) to read as follows:

(f) Section 1513(b)(3) is amended by inserting before the period at the end of the second sentence the following: "  
", and to the development and expansion of health maintenance organizations, and their facilities and equipment".

9. Amend §1527(a)(6) as added by §218(a) to read as follows:

"(6) The program shall provide that each decision of the State Agency to issue a certificate of need shall not be inconsistent with the State health plan in effect for such State under section 1524(c)."

10. Add §218(b)(7) to read as follows:

(7) Section 1532 is amended by adding at the end the following:

"(d) If a project for facilities or equipment to be used to provide substantial services to members of health maintenance organizations is denied a certificate of need by a State Agency, a health maintenance organization may immediately appeal the decision directly to the Secretary, or may appeal the decision to the Secretary after all State legal remedies have been exhausted. The appeal must be made within 60 days of the State Agency decision or the date upon which all State legal remedies are exhausted. The Secretary must decide the appeal within 60 days and shall reverse the decision if it is determined that it would discourage the operation or

expansion of a health maintenance organization which has demonstrated to the Secretary's satisfaction proof of its capability to provide comprehensive health care services (including institutional services) efficiently, effectively and economically, or it is inconsistent with the State Plan or appropriate HSP or federal law or regulations."

11. Add §220(b)(1)(C) to read as follows:

(C) by inserting after "this Act" the following:  
"except for title XIII".





# **NATIONAL INDIAN HEALTH BOARD, INC.**

BROOKS TOWERS BUILDING—ROOM 4-E  
1020-15TH STREET • DENVER, COLORADO 80202  
303/534-5492

February 24, 1978

Honorable Paul A. Rogers, Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
Room 2415, Rayburn House Office Building  
Washington, D.C. 20515

Dear Congressman Rogers:

In recent testimony before your subcommittee on health and the environment, Mr. Hale Champion, Under Secretary of HEW, stated that DHEW intended to propose amendments to Public Law 93-641, the Health Planning and Resources Development Act of 1974. We have received copy of those proposed amendments, and would like to take this opportunity to comment on them.

In the present Act, Public Law 93-641, Sec. 1513(E)(1)(a) and Sec. 1513 (E)(1)(b) mandates two functions of Health Systems Agencies which are relevant to Indian tribes and Alaska Natives. One mandate is for each Health Systems Agency to provide each Indian tribe, Indian organization, or Alaska Native organization which is located within the agency's health service area information respecting the availability of federal funds. The other mandate authorizes health systems agencies to only review and comment on all proposed uses of federal funds by Indian tribes, and organizations, and Alaska Native organizations. These two mandates have resulted in numerous unanswered questions:

- (1) Does the "review and comment" authority diminish tribal sovereignty?
- (2) Do HSA health plans supersede reservation health plans?
- (3) If, for example, reservation population figures are used in HSA health plans, and if funds are appropriated to the state areas based on that population including Indians, is a share of those funds available to Indian tribes or Alaska Natives?

Unfortunately, DHEW's proposed amendments do not address these issues. In fact, no mention of Indian tribes or Alaska Natives is made within the proposed amendments.

The National Indian Health Board, Inc. expresses its dismay that the forementioned issues have not been addressed though, DHEW has continually been requested to do so by various Indian tribes and Alaska Native organizations. NIHB feels that the rewrite and reauthorization of P.L. 93-641 presents an excellent opportunity to address the ambiguities discussed supra. NIHB, therefore, proposes these following amendments:

Amendment #1

"In carrying out their activities, HSAs shall respect the sovereign authority of Indian tribal governments in regard to health activities located within the exterior boundaries of their reservations. However, HSAs and tribal governments shall enter into agreements to promote planning and coordination on matters of mutual concern to both entities. The Secretary of DHEW shall promulgate regulations and guidelines for the implementation of this section. After consultation with Indian tribal governments, national Indian organizations, Alaska Native organizations, and HSAs affected by this provision."

Amendment #2

"Of the funds provided for under Section 1516 of this Act (operational funds for HSAs), 2% of such funds shall be set aside for grants to tribal health planning agencies, under such conditions and allocation procedures as the Secretary determines is appropriate."


Amendment #3

"Each tribal health planning office shall have the right to review and approve or disapprove the proposed use within its reservation of federal funds appropriated for health services, including funds used for the direct delivery of health services by any federal agency."

These amendments have been discussed in workshops held at the Second National Indian/Alaska Native Health Conference in Albuquerque, New Mexico, February 12-15, 1978 as well as endorsed by those participants of the same conference. The National Indian Health Board believes that these amendments will help resolve those questions previously discussed.

The National Indian Health Board appreciates the opportunity to express its concerns regarding P.L. 93-641. We hope that further communication, not only being necessary, but expedient, will develop between your Subcommittee and organizations, such as NIHB.

Sincerely,

  
 for John Belindo  
 Executive Director

cc: Mr. David E. Satterfield III



## AMERICAN DENTAL ASSOCIATION

WASHINGTON OFFICE • SUITE 1004 / 1101—17TH STREET, N.W. • WASHINGTON, D.C. 20036 • PHONE 202/833-3036

February 27, 1978

The Honorable Paul G. Rogers  
Chairman  
Subcommittee on Public Health and  
Environment  
Committee on Interstate and Foreign  
Commerce  
2415 Rayburn House Office Building  
Washington, D. C. 20515

Dear Mr. Rogers:

I am writing on behalf of the American Dental Association to express the Association's views concerning the amendments to the National Health Planning and Resources Development Act proposed by the Administration. We appreciate the efforts of Representative Satterfield and the Subcommittee in allowing time for comment on this proposal. I have included as well additional remarks concerning H.R. 10460. We also will forward to you some proposed amendments to that bill and to the existing planning law to incorporate the changes which were suggested in the testimony of Dr. I. Lawrence Kerr before your Subcommittee on February 1, 1978 as well as those proposed in this letter. I request that this letter be made a part of the record of those hearings.

The primary concern of the Association with the existing health planning law relates to the force of guidelines and other policy statements of the Department of Health, Education and Welfare. Recent experience has shown that these guidelines, which must be followed by local health systems agencies, can be very rigid and inappropriate for many local situations. We recommend amendment of the existing law to assure that guidelines, standards, and other policy statements are just that and that they cannot be arbitrarily imposed upon the actions of local agencies. This will help assure that those decisions which affect the delivery of health care services in an area will be freely made by the local agency.

In reviewing the proposed Administration legislation we are struck by the similarity between many of its provisions and provisions of H.R. 10460. Many of these are essentially aimed at improving basic efficiencies in the existing program and were commented on in our earlier testimony. Others are of considerable significance however.

Perhaps most noticeable about the Administration's proposal is the deletion of authority for resources development. We believe that this authority should be retained. While there must be continuing vigilance that federal funds are not utilized to construct unnecessary facilities, it is inappropriate to address this concern by eliminating all funding for health resources development. The Congress has already enacted certificate of need requirements with regard to the construction of new health facilities. Certainly this authority, if it is implemented properly, should help allay concerns that unnecessary facilities might be constructed.

In addition however the current health resources development authority provides for assistance for modernization of medical facilities, conversion of existing medical facilities for the provision of new health services, and construction of outpatient facilities in addition to its authority for construction of new inpatient medical facilities in areas which have experienced rapid population growth. Although there certainly should be careful review of expenditures for these purposes, the continuing need for modernization, conversion, and construction of health facilities makes elimination of this authority unjustifiable.

I also would like to express the concerns of the dental profession with changes which are proposed for the program of health resources development in H.R. 10460. We believe that it is not only important to retain this authority to make funds available for necessary modernization or construction, but also to retain control at the local level over decisions as to how funds for these purposes will be spent. Just as under the general health planning program, decisions regarding health resources development should not be subject to the centralized authority of the federal government as exemplified by the Secretary of HEW.

As emphasized in our original testimony before your Subcommittee, one of the very major concerns of the dental profession with regard to the present health planning law is that law's restrictiveness with regard to representation of, and participation by, dentists. We have prepared amendments to the law which would assure that dentists be given positions on health systems agencies, statewide health coordinating councils and the National Planning Council and urge their inclusion in any planning legislation approved by your Subcommittee.



The Administration proposal does not address this issue of specified planning entity membership for various health professionals. However we believe that provisions in the proposal to require that at least 25% of the membership of health systems agency governing bodies consist of public elected officials and other representatives of governmental authorities in the agency's health service area will detract from the effectiveness of the planning process. Currently a majority, but not more than 60%, of the members of health systems agency governing bodies and executive committees must consist of consumers of health care. The remaining members are to be providers of health care with at least one third of these direct providers. Provision is made for membership of public elected officials or other representatives of governmental authorities with no stipulation as to the percentage of such members nor as to whether or not they are to be consumer or provider members. Under the Administration approach governmental representatives would form an additional category resulting in a reduction in the percentage of provider members.

While it is appropriate to structure HSA membership so that there is an adequate role for consumers, we believe that it is imperative that there be substantial membership for those who actually are providing care in the community.

While it also is appropriate that there be representation of local government officials, we do not believe it is at all necessary that this representation consist of 25% of the total governing body membership. This would result in less than 25% membership for providers, many of whom may not be direct providers.

The issue of indirect providers also is related to this discussion. At present many individuals who are classified as indirect providers have their primary contact with the health care delivery system as consumers and they should be categorized as such. We recommend as one solution to assure appropriate participation by all interested groups a deletion of the term indirect provider, a continuation of the present provisions permitting membership for local government representatives, and a requirement that all provider representatives be direct providers. In addition there should be a mandate that dentists be included among the direct providers who serve on each HSA governing body.

The Administration proposal contains provisions to extend certificate of need requirements to include purchases of major medical equipment as is proposed in H.R. 10460. As stated in our earlier testimony there is no information on the record to justify potentially subjecting private dental offices to certificate of need requirements and we oppose inclusion of such offices in any such requirements. We recommend that there be a specific exemption for dental offices provided in this law.



Finally we wish to register our concern with provisions in H.R. 10460 which would require states to establish programs for the decertification of health care facilities within four years. We believe it is at best premature to enact such farreaching authority. The existing law and H.R. 10460 would continue authority for appropriateness review. In addition your Subcommittee already has approved legislation to provide incentives for the closure or conversion of inpatient hospital facilities. We believe that such an approach, which would encourage greater mutual agreement by all parties involved as to the necessity for and method of such closure or conversion, would be considerably more appropriate than the mandated and broadly stated approach proposed in section 219b of H.R. 10460.

In summary our concerns with the proposed amendments to the Health Planning and Resources Development Act are basically the same as our concerns with the presently existing law. In order for health planning to be truly effective there must be freedom for local health systems agencies, to make decisions based on the conditions which exist in the health service area of each agency. These decisions can be formulated within the framework of general guidelines promulgated by the federal government but these guidelines must not impede local freedom of determination. In addition we believe very strongly that it is important that there be a solid base of provider membership in all health systems agencies. This provider membership should consist of direct providers rather than the tenuous classification of indirect providers of health care. In the same manner that a solid base of consumer membership should be included in order to permit HSA decisions to effectively reflect the concerns and needs of consumers of health care, so must there be an effective reflection of the knowledge and views of those who have the primary experience in delivering this care. Finally in order for the provider members to best address the overall health care planning issues in any health service area we believe that the input of health professionals in various categories of health care should be included and therefore recommend that dental membership on health systems agencies and other planning bodies be mandated.

As mentioned in our earlier testimony the ADA has been very actively involved in the implementation of this law. We do have serious concerns with certain aspects of the law and hope to have the opportunity to continue to work with the Subcommittee in the continued development of health planning authority which is both reasonable and effective.

Again I thank you on behalf of the American Dental Association for this opportunity to add our additional comments to the discussion of these proposed amendments.

Sincerely yours,

*Frank P. Bowyer*

Frank P. Bowyer, D.D.S.  
President

FPB:cs

PHILIP ADLER, D.O., PRESIDENT \* 28050 GRAND RIVER AVENUE, FARMINGTON, MICHIGAN 48024



## *American Osteopathic Association*

February 27, 1978

The Honorable Paul G. Rogers  
Room 2407  
Rayburn House Office Building  
Washington, D.C. 20515

Dear Congressman Rogers:

On behalf of the American Osteopathic Association, I am pleased to respond to the invitation by Congressman Satterfield to comment on the "Health Planning Amendments and Hospital Services Discontinuation Act of 1978", as proposed by the Department of Health, Education and Welfare.

I would first comment on Section 206 which would permit certain providers of health care to serve on Health Systems Agencies as provider representatives although they do not fall into one of five currently specified classes. We feel that this section is vague, and undermines the original intent of the law to have actual providers serving on the HSA.

With respect to Section 208, mandating that 25 percent of the HSA members be public officials, and Sections 217 and 218 which grant to the Governor the power of appointing the Chairperson of the Statewide Health Coordinating Council, and of approving the State Health Plan, we feel that these provisions unnecessarily politicize the health planning process. We believe strongly that the local planning bodies should have primary responsibility for planning, and this includes the power of appointing the SHCC Chairperson, and determining what should most appropriately be included in the State health plan.

Additionally, we wish to bring to your attention suggested amendments by the American Osteopathic Association to the health planning law, the first of which addresses an issue of particular importance to the osteopathic profession. As we noted in our testimony before your subcommittee, we believe the following or similar language would insure that those patients desiring osteopathic care and services will have access to them; (new material underlined):

Section 1532 (c) (3) The need that the population served or to be served has for such services. The need to construct, expand or modify any osteopathic facility shall be determined on the need and availability in the community for osteopathic services and facilities.

The American Osteopathic Association also believes that it is imperative that Health Systems Agencies and the National Council have the expertise of physicians and other direct providers of health care in active practice, who are conversant with the problems facing patients and practitioners in the health care delivery system. Therefore, we have proposed the following amendments.

Sec. 1503 (b) (1) Require the National Council to include at least one physician representative selected from active practice.

Sec. 1512 (b) (3) (C) (2) Revise so as to (1) Require inclusion of at least one representative from a hospital, or hospitals, located in the area: and (2) require inclusion of at least one physician engaged in active practice in the area.

Sec. 1524 (b) (1) (C) require that (1) at least three fourths of provider members be direct providers, and (2) include at least one representative from each of the provider categories enumerated in Sec. 1512 (b) (3) (C) (11).

We appreciate your solicitation and consideration of our thoughts on the amendments to the health planning law, and would be pleased to respond to any questions you might have or provide any additional information you may require.

Sincerely,



Philip Adler, D.O.  
President

**AMERICAN HOSPITAL ASSOCIATION**

444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 202-638-1100  
WASHINGTON OFFICE

March 3, 1978

Honorable Paul G. Rogers, Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
House of Representatives  
Washington, D.C. 20515

Dear Mr. Chairman

The enclosed statement contains the comments of the American Hospital Association on H.R. 11077, the Health Planning Amendments and Hospital Services Discontinuation Act of 1978, introduced at the request of the Department of Health, Education and Welfare.

We appreciate the opportunity to provide these comments which was extended through Representative David Satterfield on February 14, 1978. We are particularly grateful for the courtesy granted to the American Hospital Association of an extra week for submission of our comments. We hope that they will be of assistance to you.

Sincerely

J. Alexander McMahon  
President

Enclosure

cc: Representative David E. Satterfield III




**AMERICAN HOSPITAL ASSOCIATION**

 444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 202-638-1100  
 WASHINGTON OFFICE

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION  
 BEFORE THE  
 SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
 HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE  
 ON  
 H.R. 11077, THE HEALTH PLANNING AMENDMENTS AND HOSPITAL SERVICES  
 DISCONTINUATION ACT OF 1978

March 3, 1978

The American Hospital Association, representing some 6,400 member institutions, including most of the hospitals in the country, and over 27,000 personal members, is pleased to have this opportunity to submit our views and recommendations on H.R. 11077, the Health Planning Amendments and Hospital Services Discontinuation Act of 1978, introduced at the request of the Department of Health, Education and Welfare. This statement is provided as a supplement to our testimony on H.R. 10460, which was delivered before the Subcommittee on February 2, 1978.

In our review and analysis of H.R. 11077, we have commented only on those provisions that appear to be of primary concern to hospitals, and those provisions which we believe warrant the careful consideration of the Subcommittee. While we support some provisions of the Administration's bill, on balance we do not believe that it represents a constructive approach to the extension of P.L. 93-641.

Our comments on selected sections of H.R. 11077 follow:

Section 101

We are particularly disturbed to note in the extension of the authorization for appropriations in four areas -- HSA grants, state agency grants, rate review assistance, and area health services development funds -- that the amounts

included are less than permitted in prior years, and, further, that these specific authorizations are only for FY 1979. This suggests to us a significant retreat from the Administration's previous support for funding of this critical program. This lack of commitment in our view could jeopardize the orderly and timely implementation of this Act. We support the three year authorizations for Sections 1516, 1525, 1526 and 1534 that are contained in H.R. 10460.

#### Section 206

This section would further loosen the requirements for provider representation on HSA boards by permitting persons who would not necessarily be direct representatives of providers to take the place of such providers on HSA boards. While the individuals associated with health care delivery are now included on HSA boards, we believe that direct representation of each of the groups specified in Section 1512(b)(3)(c)(ii) of the Act is a minimum requirement to assure necessary provider input to the local planning process. The purpose of mandating provider representation in the Act was to bring their training and expertise into the health planning decision-making process. If the purpose of this section is to further limit provider representation, we would strongly oppose the section.

#### Section 208

This section, in our interpretation, would amend the HSA board composition requirements of the Act to mandate that at least one-quarter of the provider representatives be public elected officials and other representatives of local governmental authorities. Obviously, this amendment would have the effect of substantially reducing direct provider representation on HSA boards and would thwart the intent of the original Act to provide a balance between provider and consumer representatives. In our view, the provisions of existing law assure adequate representation of public

officials. Further, we believe that the classification of public officials as consumers or providers should be consistent with the criteria applied to make such determinations for all other HSA board members. Therefore, we oppose this amendment.

#### Section 212

We strongly oppose the elimination of the capitation formula for determining the amount of HSA grants which is proposed by this section. Permitting the Secretary of Health, Education and Welfare the sole discretionary authority to determine the financial support for HSAs could seriously undermine the future viability of local planning agencies. In our view, the Congress made a commitment to financial assistance for HSAs that provides the prospect of continuity and stability that is an essential ingredient for a sound national health planning program. We would like to note our support for a provision contained in H.R. 10460 that would permit the Secretary to make adjustments to HSA grants based on specified characteristics and needs of a particular HSA, but in no event could an HSA grant be less than that permitted under the current statutory formulas.

#### Section 213

AHA supports the extension of the scope of state certificate-of-need (CON) laws to include major medical equipment costing in excess of \$150,000 regardless of ownership or setting. However, we do oppose the portion of this section which appears to exempt the services and facilities of health maintenance organizations from CON review. In our comments on Section 219, we set forth additional comments on this matter.

#### Section 214

This section would amend Section 1523(a) of the Act to require state agency CON

decisions to be consistent with the State Health Plan and the State Medical Facilities Plan. In our view, this provision is too restrictive because it cannot be reasonably anticipated that all justified needs will be identified in such plans, or that such plans can anticipate all needs in the course of a year. We recommend that flexibility be retained for state agencies in the consideration of CON applications so that approvals may be granted to projects of demonstrated need, even though they may not have been specifically included in the State Health Plan or the State Medical Facilities Plan. Such flexibility is essential to assure a reasonable and responsive review process. Therefore, we oppose this section in its present form.

#### Section 218

We offer only the comment that the notice and hearing requirements associated with the adoption of a State Health Plan, as provided under Section 1524(c) of the Act, should continue to apply to any revised SHP submitted by the SHCC as a result of a governor's veto of an earlier plan. Waiving such due process procedures could permit substantial alterations of SHPs without the input and involvement of concerned and affected parties -- both consumers and providers. We believe that the opportunity for public review and comment on the SHP in its original or revised forms should be preserved and accordingly, we oppose this section.

#### Section 219

As we noted in our comments on Section 213 of this bill, we oppose exemption of the services and facilities provided by health maintenance organizations from the review and approval process of state certificate-of-need laws. Further, in this section, we oppose delegating to the Secretary of Health, Education and Welfare the authority to establish separate review criteria for HMO facilities, services and equipment under state CON laws. All providers of health services should be

treated equitably and consistently under this regulatory program. If the intent of this section is to establish parallel and duplicative CON review criteria for HMOs, we would oppose this section.

### Title III

We support the concept of providing financial incentives and removing financial obstacles to the voluntary closure or conversion of excess hospital capacity or unneeded services. We do not believe, however, that such assistance should require a formal finding of "inappropriateness" by HSAs and state agencies, as provided for in this section. Such a requirement would assume that every HSA and state agency has in place an operating appropriateness review process. According to information we have received, the appropriateness review function is not in place yet, and, further, the Department of Health, Education and Welfare has yet to issue any guidelines or regulations to implement this process. In our judgment, the effective and timely use of a voluntary program for closure or conversion of facilities and services would be inordinately delayed if it is linked to a finding of "inappropriateness". A more reasonable approach to assuring involvement of the planning agencies in this program would be to require that applications for federal grants under this program be reviewed and recommended to the Secretary by means of the project review processes that are now in place.

We appreciate this opportunity to comment on H.R. 11077 and hope that it will be useful to the Subcommittee during their consideration of this important legislation.



Statement

of the

AMERICAN MEDICAL ASSOCIATION

Submitted to the

Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
United States House of Representatives

Re: Administration's Proposed Revisions  
to P.L. 93-641, the National Health  
Planning and Resources Development  
Act, as contained in H.R. 11077

March 6, 1978

The American Medical Association submits the following comments on H.R. 11077, the Health Planning Amendments and Hospital Services Discontinuation Act of 1978.

This bill, containing the Administration's proposed revisions to P.L. 93-641, would extend the authorization of funding for three years (until FY 1981) and make numerous substantive amendments.

The American Medical Association supports health planning as an important activity to help assure access to needed medical and health care services. However, we believe that health planning must be flexible enough to accommodate the different medical need of individual patients and to insure the availability of high quality medical care for all persons who need it. This can best be achieved by placing the planning authority and power at the local level and by insuring that those most directly involved in, and knowledgeable about, the use of medical and health services at the local level have the basic responsibility for making decisions regarding the quality, distribution, and availability of services.

The AMA earlier submitted to the Subcommittee amendments which we

believe would move the planning law more in the direction of responding to patient needs by limiting federal power and by shifting authority and responsibility for planning back to the local community. We believe these amendments should be adopted.

We are concerned that several of the amendments proposed by the Administration in H.R. 11077 would not achieve these goals, but would instead impose additional federal limitations on the autonomy of local planning agencies and could lead to the rationing of health resources.

We urge the rejection of any amendments to P.L. 93-641 that would inhibit the delivery of high quality medical care.

#### Coverage of Physicians' Offices Under Certificate of Need

H.R. 11077 would require extension of certificate of need to the physician's office by covering purchases of "major medical equipment" costing in excess of \$150,000 in any setting. Such a step represents a dramatic extension of the planning law and must be examined most carefully.

There is as yet little evidence to support the notion that certificate of need has resulted in significant cost savings in health care institutions. Until such evidence is compiled, consideration of extension of certificate of need to the physician's office would be inappropriate. Furthermore, such an extension would raise constitutional questions.

A few states have adopted programs which can provide a basis for obtaining experience with certificate of need for equipment in physicians' offices. However, until definitive evidence is compiled, we believe that any consideration of extension of certificate of need to the physician's office would be inappropriate. Further, it must be recognized that cost considerations

cannot take precedence over the necessity to maintain the quality and availability of medical care and services.

A few states have adopted programs which can provide a basis for obtaining experience with certificate of need for equipment in physicians' offices. However, until definitive evidence is compiled, we believe that any consideration of extension of certificate of need to physicians' offices is premature.

We must also consider the possible long range effects of extending certificate of need to the physicians' office. For example, restricting the physician's use of medical technology could impede the development and refinement of new medical discoveries. Such an extension could also lead to an increase in health care costs. It is well established that many procedures can be performed in the physician's office less expensively than in a hospital. Applying certificate of need to physicians' practices could restrict the performance of many of these procedures to institutional settings, thus increasing costs.

We are also concerned that this could lead to the establishment of "franchises" in medicine that will restrict the availability of medical services to patients and restrict the entry of new health professionals into the system. This would adversely affect rural and shortage areas.

For these reasons, we urge that provisions extending certificate of need to physicians' offices be deleted.

#### Conversion of Health Facilities

H.R. 11077 would establish a program of grants to hospitals to assist in discontinuing certain inpatient hospital services. Under this program, the Secretary could make grants to those hospitals which have been in operation for seven years to cover certain expenses of closing or converting services

which have been designated as inappropriate by the state health planning and development agency.

A number of proposals have been recently made designed to encourage the discontinuance or conversion of health services or facilities. Many of these programs would be mandatory, and determinations of "appropriateness" would be made according to standards promulgated by the Secretary of HEW.

We are opposed to proposals for mandatory decertification programs. Such programs raise many serious questions, and could have potential adverse effects upon the quality and availability of health care. Such questions include the availability of financing for initial construction, continued availability of health care when closure or conversion of a facility occurs, and the availability of professional services, through their effect on professional privileges and changes in practice locations. Mandatory decertification programs also carry with them the inflexibility of mandatory standards.

Therefore, we are pleased that the provisions for discontinuance or conversion in H.R. 11077 appear to be voluntary. We believe that economic incentives in a voluntary program can be an effective means of encouraging the elimination of services or facilities that may be outmoded, duplicative or unnecessary. It is far better that closure or elimination of services be initiated voluntarily at the local level.

Under the bill, each application by an institution for the conversion funds would be reviewed by the local HSA and the SHPDA. This recommendation would be forwarded to the Secretary who would have the final decision.

We recognize that expenditures of federal funds must carry a role for federal officials, but we are pleased to see that there are opportunities

for the local community to have a voice in the decision making process. This encourages local responsibility and initiative in the planning process.

While we generally support voluntary mechanisms, we have some concerns which we believe should be resolved by Congress before any action is taken on this proposal.

Would it not be better to try this program on a limited basis first in order to determine its effectiveness before a nationwide effort is undertaken?

Would the grant amounts for institutions be sufficient to cover the costs of closure or conversion and thus be a realistic incentive for institutions to undertake such activities? A limited test of this program might answer this.

Why is this proposal limited to older institutions and why would it not take effect until FY 1980?

In the main we are pleased to see this proposal which comports closely with other proposals on this subject which we have supported and recommended for trial.

#### Funding of HSAs

Under current law, the amount of funds available to a HSA is determined by a statutory formula. The Administration proposes that the amount of any grant to a HSA would, in the future, be determined solely by the Secretary.

We object to this change for two reasons. First, the absence of any guidelines as to grant amounts would make it very difficult for HSAs to predict their future funding levels for purposes of budget setting and planning of future activities.



Second, such a change would put the HSA totally at the mercy of the Secretary in terms of funding. There would be no control over the Secretary's discretion. We believe this would severely restrict the autonomy of HSAs. This increased federal control can only lead to further federal domination over the planning process. As we discussed earlier, such increased control is inimical to effective health planning.

We are also concerned that after FY 1979 an open-ended authorization level is proposed. We believe that such a change denies to Congress the opportunity to determine funding priorities. Having a specific ceiling for authorizations contributes to good Congressional budgetary planning which is so essential in this time of limited resources.

We urge that a statutory formula for grants to HSAs be retained and that appropriate ceilings be retained on authorizations.

#### Composition of HSA Governing Boards

H.R. 11077 proposes certain changes to the composition of HSA governing boards that would further reduce "provider" membership and could also further limit physician input into health planning decisions.

The first change would require that at least one quarter of the members be "public elected officials and other representatives of governmental authorities in the agency's health services area." Under present law these individuals can come from either consumer or provider representation. However, under this proposal, these representatives would be a new class in addition to consumers and providers. Their seats could not come from the consumer majority; therefore, they would have to come out of those seats now reserved for providers. Considering the fact that provider representation is already diluted by "indirect" providers, the addition of a

new special representation out of providers will further undermine true provider input.

The other change would permit providers not currently listed in the law to be represented. Currently, physicians and other health professionals, institutional representatives, insurers, health profession schools' representatives, and allied health professions are listed. Encouraging more non-physician representation can only impair the effective input of those physicians already on the board and preclude other physicians from becoming involved in local health planning activities.

We oppose both these changes because we believe that health planning decisions must have sufficient physician and provider input to be realistic and effective. To do otherwise may lead to decisions based on inadequate information that might adversely affect the availability and quality of health and medical services.

We urge that these provisions (sections 206 and 208) not be adopted. Rather we encourage an increased physician representation on planning bodies as a means of enhancing the effectiveness of the planning process. The AMA has already proposed amendments to achieve such representation.

#### Conclusion

There are many provisions in P.L. 93-641 that are ripe for change; however, several of the provisions of H.R. 11077 suggest, in our opinion, the wrong direction. Less, not more, federal control is what is needed to make health planning work in the best interests of patients. More, not less, provider input will lead to more effective, patient-oriented, planning decisions.

We again commend to your attention the AMA amendments previously submitted to the Subcommittee. We believe they will go a long way to insuring that health planning truly reflects local conditions and the medical needs of patients and we urge their adoption. H.R. 11077 in its present form should not be adopted.

[Whereupon, at 5:55 p.m., the committee adjourned.]



A large grid of graph paper, resembling a ledger or a notebook page. The grid consists of 10 columns and 20 rows. At the bottom left, there is a white rectangular area containing the NIH Library logo. The logo features the letters 'NIH' in a large, bold, sans-serif font, with a stylized graphic of three vertical bars of increasing height to the right of the 'I'. Above the 'NIH' text, the word 'LIBRARY' is written in a smaller, bold, sans-serif font. To the right of the logo, the text 'PRINTED IN U.S.A.' is printed in a small, sans-serif font.

The NIH Library logo, featuring the letters "NIH" in a large, bold, sans-serif font. Above the "H" is the word "LIBRARY" in a smaller, bold, sans-serif font. To the right of the "NIH" is a stylized graphic of a bookshelf with several books. Below the "NIH" is the word "America" in a small, italicized, sans-serif font.

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